Central Services
Human Resource
& Risk Services

City of Eugene
777 Pearl Street, Room 101
Eugene, Oregon 97401
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www.eugene-or.gov

MEMORANDUM

Date: **October 14, 2005**

To: **City of Eugene Employees**

From: **Employee Benefits Program**

Subject: City Managed Care Plan (POS) Handbooks

Until ODS Handbooks are available for employees covered under the City Managed Care (Point of Service) Plan, you can continue to use the PacificSource handbook for general administration questions. Please refer to the Summary of Benefits for your employee unit for specific coverage amounts. The Summary of Benefits is available on the Employee Benefits website Health Insurance Page or by contacting Benefits Staff at 682-8868.

Information on your plan, coverage amounts and claims is available through the **myODS** service on the ODS website at http://www.odscompanies.com. You can also contact ODS for current coverage and benefit administration questions.

COVERAGE QUESTIONS

Medical or Vision: 877-605-3229 or by email: medical@odscompanies.com
Dental: 877-277-7280 or by email: dental@odscompanies.com
Pharmacy: 888-361-1610
Mental Health & Chemical Dependency: 800-799-9391

Send Medical or Vision claims to:
ODS Health Plan, Inc.
PO Box 40384
Portland OR 97240-0384

Send Dental claims to:
ODS Health Plan, Inc.
601 SW Second Avenue
Portland OR 97204

CITY OF EUGENE – AFSCME

Group No.: 6825
PRIME 15/50D VAR
Effective: January 1, 2005

12-10-2004

PacificSource
HEALTH PLANS

Welcome to your PacificSource group health plan. Your employer offers this coverage to help you and your family members stay well, and to protect you in case of illness or injury. Your plan includes a wide range of benefits and services, and we hope you will take the time to become familiar with them.

Using this Handbook

This handbook will help you understand how your plan works and how to use it. Please read it carefully and thoroughly. Although it is only a summary, it is intended to answer most of your questions. If there is a conflict between this benefit handbook and the group health contract, this plan will pay benefits according to the contract language.

Within this handbook you'll find Member Benefit Summaries for your medical plan and any other health benefits provided under your employer's group health contract. The handbook explains the services covered by your plan; the benefit summaries tell you how much your plan pays toward expenses and how much you're responsible for.

If anything is unclear to you, the PacificSource Customer Service staff is available to answer your questions. Please give us a call, visit us on the Internet, or stop by our office. We look forward to serving you and your family.

PacificSource Customer Service Department
Phone (541) 684-5582 or (888) 977-9299
E-mail cs@pacificsource.com

PacificSource Headquarters
PO Box 7068, Eugene OR 97401-0068
Phone (541) 686-1242 or (800) 624-6052

Web site
www.pacificsource.com

Portland Marketing Office
PO Box 2129
Lake Oswego, OR 97035
Phone (503) 699-6561

Bend Marketing Office
PO Box 6837
Bend, OR 97708-6837
Phone (541) 330-8896
or (888) 877-7996

Medford Marketing Office
PO Box 1027
Medford, OR 97501
Phone (541) 858-0381
or (800) 899-5866

CONTENTS

MEMBER BENEFIT SUMMARY

POLICY INFORMATION

Group Policy Name:	CITY OF EUGENE – AFSCME
Group Policy Number:	6825825
Plan Name/Type:	PRIME 15/50D VAR

EMPLOYEE ELIGIBILITY AND PARTICIPATION REQUIREMENTS

Minimum Hour Requirement:	TWENTY (20) HOURS
Waiting Period for New Employees:	1ST OF THE MONTH FOLLOWING DATE OF HIRE

SCHEDULE OF BENEFITS

Maximum Lifetime Benefit $2,000,000

Out-of-Pocket Limit ..... $1,000 per person per calendar year

Once a member has met the out-of-pocket limit in a calendar year, this plan will pay 100% of covered charges for participating providers for the rest of that year. Benefits paid in full and nonparticipating provider charges in excess of the PacificSource fee allowance, prescription drugs, and alternative care provider charges do not accumulate toward the out-of-pocket limit.

Primary Care Practitioner

All enrolled members must select a primary care practitioner (PCP) from the plan's provider directory to be responsible for their continuing medical care. The PCP will coordinate use of healthcare resources to best meet the member's healthcare needs.

SERVICE:	***COPAY:***	***PCP OR REFERRED BENEFIT AFTER COPAY:***	***OUT-OF-PANEL/ NONREFERRED PROVIDER BENEFIT AFTER COPAY***
PREVENTIVE CARE			
Well Baby Care	$15 per visit	100%	50%
Routine Physicals	$15 per visit	100%	50%
Routine Gynecological Exams	$15 per visit	100%	50%
Hearing / Eye Exams (one exam every 24 months for children through age 18)	$15 per visit	100%	50%
Immunizations		100%	50%
PROFESSIONAL SERVICES			
Office and Home Visits	$15 per visit	100%	50%
Urgent Care Center Visits	$15 per visit	100%	50%
Surgery – at Office	$15 per visit	100%	50%
Surgery – at Facility		100%	50%
Maternity – Physician Services	$25 per pregnancy	100%	50%
HOSPITAL SERVICES			
➢ Inpatient Room and Board	$50 per day	100%	50%
➢ Inpatient Rehabilitative Care	$50 per day	100%	50%
➢ Skilled Nursing Facility Care	$50 per day	100%	50%
➢ Maternity – Facility	$50 per day	100%	50%
OUTPATIENT SERVICES			
Outpatient Surgery	$20 per visit	100%	50%
Diagnostic / Therapeutic Radiology and Lab	10% up to $25 max per visit	100%	50%
CT Scans and MRIs	10% up to $75 max per visit	100%	50%
• Emergency Room Visits	$100 per visit	100%	50%

- ***In true medical emergencies, nonparticipating providers are paid at the participating provider level.***
- ➢ ***Copay subject to 5-day maximum.***

	SERVICE:	*COPAY:*	*PCP OR REFERRED BENEFIT AFTER COPAY:*	*OUT-OF-PANEL/ NONREFERRED PROVIDER BENEFIT AFTER COPAY*
	MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES			
	Office Visits		80%	50%
	Inpatient Care		80%	50%
	Residential Programs		80%	50%
	OTHER COVERED SERVICES			
	Physical Therapy	$15 per visit	100%	50%
	Allergy Injections		100%	50%
	Ambulance	$50 per transport	100%	100%
	Durable Medical Equipment		80%	50%
	Home Health Care		100%	50%
	Hearing Aid ($1000 max every 36 months)		50%	50%
	TMJ		50%	Not covered
*	Infertility (subject to limitations)		50%	Not covered
	Hospice Care ($15,000 lifetime max.)		100%	50%
	Alternative Care (12 visits max per year)	$15 per visit	100%	100%

- ***In true medical emergencies, nonparticipating providers are paid at the participating provider level.***
- ***Copay subject to 5-day maximum.***
- **** Invitro fertilization, experimental or investigational, and reversal of sterilization services are not covered.***

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Although participating providers accept the fee allowance as payment in full, nonparticipating providers may not. To receive the maximum benefits under this plan, members should first seek treatment from their PCP.

ALTERNATIVE CARE BENEFIT SUMMARY

Your plan's alternative care benefit allows you to receive treatment from alternative care practitioners – defined as naturopaths, acupuncturists, chiropractors, massage therapists, and dieticians - for certain healthcare services. Services of these alternative care practitioners are subject to a **$15 copayment** per office visit.

Covered Services

- Services of a licensed **naturopath** for medically necessary diagnosis and treatment of illness or injury.
- **Acupuncture services** of a licensed acupuncturist or physician for diagnosis and treatment of illness or injury.
- Services of a licensed **chiropractor** for medically necessary diagnosis and treatment of illness or injury.
- Services of a licensed **massage therapist** as medically necessary.
- One consultation with a **registered dietician** is covered.

Maximum Benefit

The combined benefit for all treatments, services, and supplies provided or ordered by alternative care practitioners is limited to **12 visits per person in any calendar year.**

Ancillary Services Ordered by Alternative Care Practitioners

Your alternative care practitioner may perform or order other medically necessary services covered by your health plan, such as laboratory tests, x-rays, radiology, or durable medical equipment. Benefits for those services are paid according to your health plan's Member Benefit Summary.

Excluded Services

Your alternative care benefit does not cover the following:

- Drugs, homeopathic medicines, or homeopathic supplies furnished by an alternative care practitioner.
- Services of an alternative care practitioner for pregnancy or childbirth.
- Any service or supply not otherwise covered by your plan.

D

PHARMACY BENEFIT SUMMARY

Your PacificSource health plan includes coverage for prescription drugs and contraceptives, subject to the limitations and exclusions described below. It also covers diabetic supplies and bee sting kits – see Other Covered Supplies, below.

COPAYMENTS

Each time a prescription drug is dispensed, you are responsible for a copayment. Copayments under your plan are as follows:

From a participating Caremark® pharmacy using the PacificSource Pharmacy Program (see below):	**Generic**	**Formulary Brand Name**	**Nonformulary**
Up to 34 day supply:	50%	50%	$20 copay or 50%, whichever is greater
Up to 30 day supply for self-injectibles:	50%	50%	$20 copay or 50%, whichever is greater
From the Walgreens Healthcare Plus mail order service:			
Up to 100 day supply:	$20	$20	$30 or 25%, whichever is greater, up to $60 max
Up to 30 day supply for self-injectibles:	$20	$20	$30 or 25%, whichever is greater, up to $60 max
From a participating Caremark® pharmacy without using the PacificSource Pharmacy Program (see below) or from a nonparticipating pharmacy):	50% or the Caremark® pharmacy copayment above, whichever is greater		

MAXIMUM OUT OF POCKET EXPENSE

The copayment for prescription drugs obtained from a participating pharmacy will be waived during the remainder of a calendar year in which your or your enrolled dependent's out-of-pocket expenses (copayments) reach $1,300. The out-of-pocket maximum applies separately to each member.

In order for the copayment to be waived, you or your enrolled dependent must present your identification card to the participating pharmacy at the time of purchase and the participating pharmacy must submit the claim electronically on-line.

Expenses incurred at participating pharmacies accumulate toward the out-of-pocket maximum, but expenses incurred for mail order prescription drugs do not.

USING THE PACIFICSOURCE PHARMACY PROGRAM

The Caremark® participating pharmacy network includes about 98% of all independent and large chain pharmacies in the United States. It also includes drugstore.com, an Internet-based pharmacy service.

To use the PacificSource pharmacy program, you must show the Caremark® plan number on your PacificSource ID card at the participating pharmacy to receive your plan's highest benefit level. Except for mail order service (see below), the PacificSource pharmacy program cannot be accessed without the Caremark® plan number printed on your PacificSource ID card. That plan number – V154, V222, or V363 plus a four-digit number – allows the pharmacy to collect the appropriate copayment from you and bill PacificSource electronically for the balance. When you use your PacificSource ID card at participating Caremark® pharmacies, the pharmacy will charge you the lesser of your copayment or the pharmacy's discounted drug cost plus service fee. For example, if your copayment is $10 and the drug's discounted cost plus service fee is only $7.50, a Caremark® participating pharmacy will only charge you $7.50.

If you don't present your PacificSource ID card at the time of purchase, or if you use a nonparticipating pharmacy, you will need to file a claim for reimbursement and your benefits will be reduced. To submit a claim, send PacificSource your pharmacy receipt, your group name and number, your name and member ID number, and the patient's name and relationship to you. We will reimburse you either 50% of the retail price, or the retail price less your plan's retail copayment, whichever is less.

Mail Order Service

Mail order prescription service is also available through your plan. If you take a medication on a regular basis, the Walgreens Healthcare Plus mail order service is a convenient way to order prescriptions and have them delivered directly to your home. If you're ordering more than a 30 day supply, you may save money on copayments, and there's no shipping or handling charge. For more information, please see the Walgreens Healthcare Plus brochure available from your plan administrator or PacificSource, or visit Walgreens Healthcare Plus online at www.walgreenshealth.com.

OTHER COVERED SUPPLIES

Supplies covered under the pharmacy plan are in place of, not in addition to, those same covered supplies under the medical plan.

Fluoride is available for your plan's generic copayment.

Diabetic Supplies

- Insulin and diabetic syringes are available for your plan's generic copayment.
- Lancets and test strips are available for your plan's formulary brand copayment.
- Glucagon recovery kits are available for your plan's formulary brand name copayment. You may purchase up to two kits at one time, but no more than four kits in any calendar year (unless otherwise preauthorized by PacificSource).
- Glucostix and glucose monitoring devices are not covered under this pharmacy benefit, but are covered under your medical plan's durable medical equipment benefit.

Bee Sting Kits

Anaphylactic recovery kits (for people with severe allergic reactions to bee stings) are available for your plan's nonformulary drug copayment. You may purchase up to two kits at one time, but no more than four kits in any calendar year (unless otherwise preauthorized by PacificSource).

Contraceptives

- Oral Contraceptives
- Depo Provera injection. You are responsible for three formulary brand name copays per injection.
- Preven. You are responsible for one formulary brand name copay.
- Lunelle injection. You are responsible for one formulary brand name copay per injection.
- Diaphragm or Cervical Cap for your plan's generic copayment
- The insertion, removal, and cost of IUD devices are covered under your medical plan benefits as a professional office visit and office supply.
- The insertion, removal, and cost of Norplant devices are covered under your medical plan benefits as a professional office visit and office supply.

LIMITATIONS AND EXCLUSIONS

- This plan only covers drugs prescribed by a licensed physician (or other licensed practitioner eligible for reimbursement under your plan) prescribing within the scope of his or her professional license.
- Certain drugs require preauthorization by PacificSource in order to be covered. Caremark® maintains the list of drugs requiring preauthorization and will request preauthorization on your behalf when necessary.
- Quantities are limited to no more than a 34 day supply at retail and 100-day supply at Walgreens Healthcare Plus mail order service of any drug per fill or refill. Self injectibles are limited to no more than a 30-day supply.
- PacificSource may limit certain specified drugs to less than a 34 day supply per copayment.

- For drugs purchased at nonparticipating pharmacies or at participating pharmacies without using the PacificSource pharmacy program, reimbursement is limited to an allowable fee. That fee is the wholesale acquisition cost of the medication plus 20%.
- Your share of the cost for prescription drugs does not apply to your medical plan's out-of-pocket maximums. Prescription drug copayments are still your responsibility even if the medical plan's out-of-pocket maximum is satisfied.
- Prescription drug benefits are subject to your plan's coordination of benefits provision. (For more information, see Claims Payment–Coordination of Benefits in your Member Benefit Handbook.)
- Your prescription drug plan does not cover:
  - Over-the-counter drugs
  - Drugs for any condition excluded under the health plan. That includes drugs intended to promote fertility, treatments for obesity or weight loss, smoking cessation drugs, experimental drugs, and drugs available without a prescription (even if a prescription is provided).
  - Immunizations (although certain immunizations are covered under your health plan's preventive care benefit – please refer to your Member Benefit Handbook)
  - Viagra and other drugs and devices to treat impotency
  - Drugs used as a preventive measure against hazards of travel

GENERAL INFORMATION ABOUT PRESCRIPTION DRUGS

Formulary Drugs

A drug formulary is a list of preferred medications used to treat various medical conditions. The formulary is used to help control rising healthcare costs while ensuring that you receive medications of the highest quality. It is a guide for your doctor and pharmacist in selecting drug products that are safe, effective, and cost efficient. The formulary is made up of both generic and name brand products. Your plan covers both formulary and nonformulary drugs, but your copayment for nonformulary drugs is higher. Nonformulary drugs are covered medications not on the Caremark® formulary.

The current Caremark® formulary includes over 750 commonly prescribed brand name and generic medications. The formulary is developed by Caremark® in cooperation with PacificSource.

Generic Drugs

Generic drugs are equivalent to name brand medications. Name brand medications (such as Valium) lose their patent protection after a number of years. At that time any drug company can produce the drug, and the manufacturer must pass the same strict FDA standards of quality and product safety as the original manufacturer. Generic drugs are less expensive than brand name drugs because there is more competition and there is no need to repeat costly research and development. Your pharmacist and doctor are encouraged to use generic drugs whenever they are available.

H

USING THE PROVIDER NETWORK

This section explains how your plan's benefits differ depending on how you access care. This information is not meant to prevent you from seeking treatment from any provider if you are willing to take increased financial responsibility for the charges incurred.

All healthcare providers are independent contractors. PacificSource cannot be held liable for any claim or damages for injuries you experience while receiving medical care.

Risk-sharing Arrangements

Your PacificSource health plan may include "risk-sharing" arrangements with physicians and other providers. Under a risk-sharing arrangement, the healthcare providers responsible for delivering services are subject to some financial risk or reward for the services they deliver.

EXAMPLE

A health plan has a risk-sharing arrangement with a group of heart surgeons. The surgeons agree to provide all the heart operations needed by the health plan's members, and the health plan agrees to pay the surgeons a fixed monthly amount for those services.

If you would like more specific information about any risk-sharing arrangements between PacificSource and your plan's providers, please contact our Customer Service Department.

YOUR PRIMARY CARE PRACTITIONER

A primary care practitioner (PCP) is a participating family practitioner, pediatrician, internist, nurse practitioner, or women's care specialist for your plan who you choose to be responsible for your medical care. Your PCP is responsible for providing preventive care services, treating your illnesses, and coordinating all your medical care including specialist services, hospital services, and urgent medical needs.

When enrolling in this plan, you and your family members must each select a PCP from the plan's provider directory. Your family members may each choose a different PCP, or share the same one. Your PCP is extremely important since the PCP will be the first person you call when you need medical care. The PCP assumes primary responsibility for medical care, requests referral for more specialized services when needed, and maintains your medical records. If your PCP is unavailable when you call, ask for the physician on call for your PCP.

Once you and your family members have chosen a PCP, you may want to phone the practitioner's office and introduce yourself as a new PacificSource patient. When you call, you may arrange for your medical records to be transferred and find out how to contact your PCP after hours.

Changing PCPs

You may change your PCP by contacting PacificSource Customer Service, or by using the electronic form on our Web site under "For Members."

PacificSource Customer Service:
Phone (541) 684-5582 or (888) 977-9299
E-mail cs@pacificsource.com

The PCP change will be effective on the first of the month after we receive your request. Please note that when you change your PCP, all current specialist referrals from your former PCP become invalid and you need to request new referrals from your new PCP.

REFERRALS

When you and your PCP decide that services of a specialist are necessary, your PCP will request a referral on your behalf. Your PCP will contact the appropriate referral management coordinator and request that you be referred to a participating specialist. If the referral is approved, you may see the specialist designated on the referral authorization. The referral authorization will specify which services may be performed by the specialist, such as consultations, tests, or surgery.

Services that Do Not Require a Referral

Referral authorization is not required for the following types of treatment:

- **Women's routine gynecological exams.** You may visit your PCP or any participating women's healthcare provider without a referral for annual preventive gynecological exams.
- **Obstetric care and delivery.** You do not need a referral to access maternity and delivery care from a participating women's healthcare provider. Women's healthcare providers include obstetricians, gynecologists, physician assistants specializing in women's health, and certified nurse midwives.
- **Mental health and chemical dependency outpatient services.** You do not need a referral for office visits to a participating mental health or chemical dependency provider.

Accessing Specialist Care Without a Referral

If you are willing to pay more out of your own pocket, you may seek the care of a specialist without referral from your PCP. If services are performed by a specialist without an approved referral authorization, benefits will be paid at the nonreferred provider percentage shown on your Member Benefit Summary. In this case, the nonreferred benefit applies even if the specialist is a participating provider for your plan. Keep in mind that services of nonparticipating providers are still subject to all the other limitations and exclusions that apply to covered services under this plan.

URGENT AND EMERGENCY CARE

Your PCP is responsible for providing and arranging all your medical care, including urgent and emergency care whenever possible. Your plan does not cover routine healthcare rendered in a hospital emergency room or urgent care facility. By understanding the difference between urgent care and emergency care and following your plan's guidelines for accessing treatment, you will maximize your plan's benefits and keep your out-of-pocket costs to a minimum.

Urgent Care

Urgent care is unscheduled medical care for an illness or injury that is not life-threatening. Examples of urgent care situations include sprains, cuts, and illnesses.

In any medical situation when the patient's life or health is not in immediate danger, call your PCP first. If your PCP is unavailable, ask to speak to the physician on call. The physician will advise you where to go for medical treatment.

Emergency Care

Emergency care is care which cannot be delayed due to injury or sudden illness, when a delay for the time required to reach a PCP or participating hospital would mean risking permanent damage to the patient's health.

An *emergency medical condition* is an injury or sudden illness so severe that a prudent layperson with an average knowledge of health and medicine would expect that failure to receive immediate medical attention would risk seriously damaging the health of a person or fetus. Examples of emergency medical conditions include (but are not limited to):

- Unusual or heavy bleeding
- Sudden abdominal or chest pains
- Suspected heart attacks
- Major traumatic injuries
- Serious burns
- Poisoning
- Unconsciousness
- Convulsions or seizures
- Difficulty breathing
- Sudden fevers

The following services are **not** considered emergency care: routine physical or eye exams, diagnostic work-ups for chronic conditions, routine prenatal care, elective surgery, and scheduled follow-up visits for emergency conditions.

If you need immediate assistance for a medical emergency, call 911. If you have an emergency medical condition, you should go directly to the nearest emergency room or appropriate facility and then call your PCP as soon as possible. Care for a true medical emergency is covered at PCP or referred benefit percentage shown on your Member Benefit Summary even if you are treated at a nonparticipating hospital. If you are admitted to a nonparticipating hospital after your emergency condition is stabilized, PacificSource may require you to transfer to a participating facility in order to continue receiving benefits at the plan's highest benefit level.

PAYMENT TO PROVIDERS

Participating providers contract with PacificSource to furnish medical services and supplies to members enrolled in this plan for a set fee. That fee is called the contracted reimbursement rate. Participating providers agree not to charge more than the contracted reimbursement rate. Participating providers bill PacificSource directly, and we pay them directly. When you receive covered services or supplies from a participating provider, you are only responsible for the amounts shown on your Member Benefit Summary. Depending on your plan, those amounts can include a deductible, copayment, or coinsurance payment.

PacificSource contracts directly with participating providers throughout our Oregon service area, and in bordering communities in southwest Washington and western Idaho. Participating PCPs, specialists, other healthcare professionals, hospitals, medical facilities, and medical supply vendors are listed in this plan's participating provider directory. In addition to the listed participating providers, PacificSource has agreements with a number of medical centers and specialized treatment programs to handle services such as transplants, neonatal care, and open heart surgery. If you need services for which PacificSource has provider contracts, you will be required to use the contracted providers for your treatment to be covered at the plan's highest benefit level.

We also have an agreement with a nationwide provider network, The First Health® Network, that includes more than 275,000 participating physicians and 3,300 participating hospitals. The First Health providers outside our service area are also considered PacificSource participating providers under your plan.

It is not safe to assume that when you are treated at a participating medical facility, all services are performed by participating providers. Whenever possible, you should arrange for professional services such as surgery, anesthesiology, and emergency room care to be provided by a participating provider. Doing so will help you maximize your benefits and limit your out-of-pocket expenses.

Nonparticipating providers are physicians, other healthcare professionals, hospitals, medical facilities, or medical supply vendors who do not have an agreement with PacificSource to provide services for this plan's members.

Nonreferred provider means any physician, healthcare professional, hospital, medical facility, or medical supply vendor other than your PCP from whom you receive nonemergency care without an authorized referral. Nonreferred providers can be participating or nonparticipating providers.

PCP or Referred Provider Benefits

For covered services, this plan pays benefits at the level shown on your Member Benefit Summary for "PCP or Referred Benefit After Copay:"

- When you are treated by your PCP
- When you are treated by another provider with an authorized referral from your PCP
- When you are treated by a participating provider for services that do not require a referral
- In a true medical emergency

In those cases, you are only responsible for the amounts shown on your Member Benefit Summary. Those amounts may include a copayment, a coinsurance payment, or both.

Nonreferred Provider Benefits

Except for true medical emergencies and services that do not require a referral, your benefits are reduced if you are treated by a provider other than your PCP without an authorized referral.

- *For nonreferred services of participating providers*, we pay the provider at the percentage shown in the "Out-of-Panel/Nonreferred Provider" column of your Member Benefit Summary.

- *For nonreferred services of nonparticipating providers,* we determine the allowable fee, then pay the provider at the percentage shown in the "Out-of-Panel/Nonreferred Provider" column of your Member Benefit Summary. Our allowable fee is a fixed amount, and it depends on the specific service or supply and the geographic area where it is provided. Many times our allowable fee is based on the prevailing contracted reimbursement rate we pay participating providers for the same service or supply. In other cases, our allowable fee may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), Concentra Preferred Systems, Ingenix, Inc., other nationally recognized databases, or PacificSource.

  For nonparticipating providers, our allowable fee is often less than the provider's charge. In that case, the difference between our allowable fee and the provider's billed charge is also your responsibility. That amount does not count toward this plan's out-of-pocket maximum. It also does not apply toward any copayments required by the plan. In any case, after any copayments, the amount PacificSource pays to a nonparticipating provider will not be less than 50 percent of the allowable fee for a like service or supply.

Example of Provider Payment

The following illustrates how payment could be made for a covered service billed at $120 under three different scenarios: with an authorized referral, from a participating provider without a referral, and from a nonparticipating provider without a referral. This is only an example; your plan's benefits may be different.

	With Referral	Par Provider, No Referral	Nonpar Provider, No Referral
Provider's usual charge……..	$120	$120	$120
Billed charge after negotiated provider Discounts……..	$100	$100	$120
PacificSource's allowable fee……	$100	$100	$100
Allowable fee less patient copayment……..	$90	$90	$90
Percent of payment (after copayment) from Benefit Summary……	100%	50%	50%
PacificSource's payment…….	**$90**	**$45**	**$45**
Patient's responsibility:			
Copayment……	$10	$10	$10
Patient's amount of allowable fee (after copayment)……	$0	$45	$45
Difference between allowable fee and billed charge after discounts……	$0	$0	$20
Patient's total payment to provider…….	**$10**	**$55**	**$75**

COVERAGE WHILE TRAVELING

Your PacificSource plan provides benefits when you travel outside the boundaries of the PacificSource provider network. Currently, the PacificSource provider network covers:

- All of Oregon
- In Washington: Clark, Cowlitz, Klickitat, Pacific, Skamania, and Wahkiakum Counties
- In Idaho: Gem, Payette, and Washington Counties

When you need medical services outside those areas, you can save out-of-pocket expense by using the participating providers available through our contracted national provider network, The First Health® Network, whenever possible.

- **Whenever possible, call your PCP first.** Your PCP will direct you to the appropriate setting for care, such as an emergency room, urgent care clinic, or physician's office. If you are traveling outside the boundaries of the PacificSource network described above, you can then call The First Health® Network at (800) 449-9905 to find a participating provider in your area. (The phone number is also printed on your PacificSource ID card for convenience.) Representatives are available Monday through Friday, 5 a.m. to 5 p.m. Pacific time to help you find a participating physician, hospital, or other outpatient provider.
- **In a medical emergency**, you should seek immediate treatment, then call your PCP as soon as possible (within 24 hours). For emergencies, your plan pays benefits at the participating provider level regardless of your location. Your covered expenses are based on our allowable fee. If you are admitted to a hospital as an inpatient following the stabilization of your emergency condition, your physician or hospital should contact the PacificSource Medical Affairs Department at (800) 624-6052 as soon as possible to authorize your admission. If you are admitted to a nonparticipating hospital, PacificSource may require you to transfer to a participating facility once your condition is stabilized in order to continue receiving benefits at the plan's highest benefit level.
- **If it is not an emergency**, you must have a referral from your PCP to receive your plan's highest level of benefits.

DEPENDENT CHILDREN RESIDING OUTSIDE THE PRIME PLAN SERVICE AREA

Covered children 19 years of age or younger who are in the custody of another parent and residing outside the Prime Plan Service Area are not required to use the services of a Prime Plan Primary Care Physician to receive benefits from this plan (this does not apply to children residing outside the service area only for the purpose of attending school). These dependent children may access the highest level of benefits by using the service of a PacificSource participating provider or provider in the First Health Network (see Finding Participating Provider Information below).

FINDING PARTICIPATING PROVIDER INFORMATION

You can find up-to-date participating provider information:

- By asking your healthcare provider if he or she is a participating provider for PacificSource Prime plans.
- On the PacificSource Web site, www.pacificsource.com. Simply click on "Provider Directory" and you can easily look up participating providers or print your own customized directory.
- By contacting the PacificSource Customer Service Department. Our staff can answer your questions about specific providers. If you'd like a complete provider directory for your plan, just ask—we'll be glad to mail you a directory free of charge.
- By calling The First Health® Network at (800) 449-9905 if you live outside the area covered by the PacificSource provider network. (Be sure to call your PCP first, though.)

BECOMING COVERED

ELIGIBILITY

Employees

Your employer decides the minimum number of hours employees must work each week to be eligible for health insurance benefits. Your employer may also require new employees to satisfy a probationary waiting period before they are eligible for benefits. Your employer's eligibility requirements are shown on your Member Benefit Summary. All employees who meet those requirements are eligible for coverage.

Family Members

While you are insured under this plan, the following family members are also eligible for coverage:

- Your legal spouse or your qualified domestic partner
- Your or your qualified domestic partner's unmarried dependent children under age 19
- Your or your qualified domestic partner's unmarried dependent children age 19 to 23 who are full-time students
- Your or your qualified domestic partner's unmarried children age 19 or over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since age 19 because of a mental or physical disability. PacificSource requires documentation of the disability from the child's physician, and will review the case before authorizing coverage.

"Dependent children" means any natural, step, and adopted children you are legally obligated to support or contribute support for. It may also include any siblings, nieces, nephews, or grandchildren under age 19 and expected to live in your household for at least a year, if you are the court appointed legal custodian or guardian.

No family or household members other than those listed above are eligible to enroll under your coverage.

ENROLLING DURING THE INITIAL ENROLLMENT PERIOD

The "initial enrollment period" is the 31-day period beginning on the date a person is first eligible for enrollment in this plan. Everyone who becomes eligible for coverage has an initial enrollment period.

When you satisfy your employer's probationary waiting period and become eligible to enroll in this plan, you and your eligible family members must enroll within the initial enrollment period. If you miss your initial enrollment period, you may be subject to a waiting period. [For more information, see "Special Enrollment Periods" and "Late Enrollment" under Enrolling After the Initial Enrollment Period.] To enroll, you must complete and sign an enrollment application, which is available from your employer. The application must include complete information on yourself and your enrolling family members. Return the application to your employer, and your employer will send it to PacificSource.

Coverage for you and your enrolling family members begins on the first day of the month after you satisfy your employer's probationary waiting period. The probationary waiting period is shown on your Member Benefit Summary. Coverage will only begin if PacificSource receives your enrollment application and premium with your employer's premium payment for that month.

Newborns

Your newborn baby is eligible for enrollment under this plan during the 31-day initial enrollment period after birth. To add the child to your coverage, you must submit an enrollment application listing the child as your dependent.

- If additional premium is required, then the baby's eligibility for enrollment will end 31 days after birth if PacificSource has not received an enrollment application and premium. Premium is charged from the date of birth and prorated for the first month.
- If no additional premium is required, then the baby's eligibility continues as long as you are covered. However, PacificSource cannot enroll the child and pay benefits until we receive an enrollment application listing the child as your dependent.

Adopted Children

When a child is placed in your home for adoption, the child is eligible for enrollment under this plan during the 31-day initial enrollment period after placement. "Placement" means you have assumed financial responsibility for the support and care of the child in anticipation of adoption. To add the child to your coverage, you must complete and submit an enrollment application listing the child as your dependent.

- If additional premium is required, then the child's eligibility for enrollment will end 31 days after placement if PacificSource has not received an enrollment application and premium. Premium is charged from the date of placement and prorated for the first month.
- If no additional premium is required, then the child's eligibility continues as long as you are covered. However, PacificSource cannot enroll the child and pay benefits until we receive an enrollment application listing the child as your dependent.

Family Members Acquired by Marriage

If you marry, you may add your new spouse and any newly eligible dependent children to your coverage during the 31-day initial enrollment period after the marriage. PacificSource must receive your enrollment application and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the marriage.

Family Members Placed in Your Guardianship

If a court appoints you custodian or guardian of an eligible sibling, niece, nephew, or grandchild, you may add that family member to your coverage. To be eligible for coverage, the family member must be unmarried, under age 19, and expected to live in your household for at least a year. PacificSource must receive your enrollment application and additional premium during the 31-day initial enrollment period beginning on the date of the court appointment. Coverage will then begin on the first day of the month following the date of the court order.

Qualified Medical Child Support Orders

This health plan complies with qualified medical child support orders (QMCSO) issued by a state court or state child support agency. A QMCSO is a judgment, decree, or order, including approval of a settlement agreement, that provides for health benefit coverage for the child of a plan member.

If a court or state agency orders coverage for your spouse or child, they may enroll in this plan within a 31-day initial enrollment period beginning on the date of the order. Coverage will become effective on the first day of the month after PacificSource receives the enrollment application.

Domestic Partners

In order for a domestic partner to qualify for enrollment, all the following criteria must be met:

- The employee and partner are each eighteen (18) years of age or older;
- The employee and partner share a close personal relationship;
- The employee and partner are not related by blood closer than would bar marriage in the State of Oregon or the state where they have a permanent residence and are domiciled.
- The employee and partner are jointly financially responsible for each other's common welfare, including basic living expenses.
- The employee and partner have lived together as a domestic partnership with the intent to continue to do indefinitely and have met all other criteria set forth in this section for a minimum of twelve (12) months;
- Neither the employee nor the partner is married to anyone else or has another domestic partner;
- The employee and partner were mentally competent to consent to contract when their domestic partnership began and remain mentally competent;
- The employee and partner each acknowledge that they are bound by and subject to all provisions of the health plan in which they enroll and any additional provisions of the domestic partnership endorsement;
- The employee and partner each acknowledge they understand that falsification of information contained in their Affidavit of Domestic Partnership or their enrollment application may result in the termination of their enrollment in the health plan and could result in a claim for damages for losses sustained by the health plan because of such falsification;
- The employee and partner each acknowledge that they understand that any coverage obtained by reason of statements attested to in their Affidavit of Domestic Partnership will terminate if they fail to meet any of the requirements as well as any applicable requirements of the underlying health plan and the domestic partner endorsement;

- The employee and partner agree to notify the health plan policyholder in writing within 31 days of any change which would cause them to fail to meet any requirement of their Affidavit of Domestic Partnership, the underlying health plan, or the domestic partnership endorsement;

Children of domestic partners. Children of enrolled domestic partners are eligible on the same terms and conditions as dependent children of enrolled employees.

Eligible partners: A qualified domestic partner may enroll by submitting an enrollment application and a completed Domestic Partnership Affidavit, which has been signed by the employee and accepted by PacificSource. The enrollment application and affidavit must be submitted within 31 days of the employee's initial eligibility period or within 31 days of the domestic partner first becoming eligible according to the criteria set forth in the Eligibility section of the policy.

If enrollment is not accomplished within the 31-day period set forth above and the domestic partnership has existed for at least twelve months, the partner will be considered a late enrollee and will be subject to policy provisions for late enrollment. Late enrollment provisions will not apply if the partner qualifies for enrollment under the other provisions of the Enrollment section of the policy.

Termination of a domestic partner's coverage. A domestic partner's eligibility for benefits under this policy will terminate upon the death of the employee, or at the end of the domestic partnership due to a change in one or more of the qualifying criteria specified in the Eligibility section, whichever occurs first. The employee and partner are required by the domestic partnership affidavit to give written notice to the policyholder within 31 days of any change in qualifying criteria.

Termination of coverage for a domestic partner's children. Coverage for children of a domestic partner not related to the enrolled employee by birth or adoption will terminate upon the death of the employee or partner, termination of the domestic partnership, or loss of eligibility as a dependent child according to the terms of the policy, whichever occurs first.

Continuation and conversion to portability coverage. Domestic partners and their children have the same rights to continuation of coverage and individual portability coverage as dependents.

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

Returning to Work after a Layoff

If you are laid off and then rehired by your employer within twelve months, you will not have to satisfy another probationary waiting period. Your health coverage will resume the first day of the month in which you return to work and again meet your employer's minimum hour requirement. If your family members were covered before your layoff, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment application within the 31-day initial enrollment period following your return to work.

Returning to Work after a Leave of Absence

If you return to work after an employer-approved leave of absence of twelve months or less, you will not have to satisfy another probationary waiting period. Your health coverage will resume the first day of the month in which you return to work and again meet your employer's minimum hour requirement. If your family members were covered before your leave of absence, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment application within the 31-day initial enrollment period following your return to work.

Returning to Work after Family Medical Leave

If you work for a company that employs 50 or more people, your employer is probably subject to the Family Medical Leave Act (FMLA). To find out if you have rights under FMLA, ask your health plan administrator. Under FMLA, if you return to work after FMLA medical leave, you will not have to satisfy another probationary waiting period or any previously satisfied reduced benefit period under this plan. Your health coverage will resume the day you return to work and meet your employer's minimum hour requirement. If your family members were covered before your leave, they can also resume coverage at that time if you re-enroll them within the 31-day initial enrollment period following your return.

Special Enrollment Periods

Your employer requires all eligible employees to participate in this plan and *you* must enroll during your initial enrollment period. However, your *family members* may decline coverage, and they may enroll in the plan later if they qualify under Rule #1 or Rule #2 below.

- Special Enrollment Rule #1

  If you declined enrollment for yourself or your family members because of other health insurance coverage, you or your family members may enroll in the plan later if the other coverage ends involuntarily. "Involuntarily" means coverage ended because continuation coverage was exhausted, employment terminated, work hours were reduced below the employer's minimum requirement, the other insurance plan was discontinued, the employer's premium contributions toward the other insurance plan ended, or because of death of a spouse, divorce, or legal separation. To do so, you must request enrollment within 31 days after the other health insurance coverage ends. Coverage will begin on the first day of the month after the other coverage ends.

- Special Enrollment Rule #2

  If you acquire new dependents because of marriage, birth, or placement for adoption, you may be able to enroll yourself and/or your newly acquired dependents at that time. To do so, you must request enrollment within 31 days after the marriage, birth, or placement for adoption. In the case of marriage, coverage begins on the first day of the month after the marriage. In the case of birth or placement for adoption, coverage begins on the date of birth or placement.

Late Enrollment

A "late enrollee" is an otherwise eligible employee or dependent who does not qualify for a special enrollment period explained above, and who:

- Did not enroll during the 31-day initial enrollment period; or
- Enrolled during the initial enrollment period but discontinued coverage later.

Late enrollees are subject to an enrollment waiting period and may enroll at the group's next renewal date as stated below

Open Enrollment Period: EMPLOYER DESIGNATED

Effective Date of Coverage Upon Enrollment: JULY 1

EXAMPLE

Your husband does not enroll in this plan when he first becomes eligible. When he decides to enroll in this plan several months later, he will be a late enrollee. His PacificSource coverage will begin at the group's next renewal date.

TERMINATING COVERAGE

If you leave your job for any reason or your work hours are reduced below your employer's minimum requirement, coverage for you and your enrolled family members will end. Coverage ends on the last day of the last month in which you worked full time and for which a premium was paid. You may, however, be eligible to continue coverage for a limited time; please see the Continuation section of this handbook for more information.

You can voluntarily discontinue coverage for your enrolled family members at any time by completing a Termination of Dependent Coverage form and submitting it to your employer. Keep in mind that once coverage is discontinued, your family members may be subject to the late enrollment waiting period if they wish to re-enroll later.

Divorced Spouses

If you divorce or legally separate, coverage for your spouse will end on the last day of the month in which the divorce decree or legal separation is final. You must notify your employer of the divorce or separation, and continuation coverage may be available for your spouse. If there are special child custody circumstances, please contact the PacificSource Membership Services Department. Please see the Continuation section for more information.

Dependent Children

When your enrolled child reaches age 19, PacificSource will send you a questionnaire regarding the child's dependent status. If at that time the child is an unmarried full-time student who you support, the child may remain under your coverage. We will then check with you annually until age 23 to verify that the child is still an eligible dependent under your plan. When the child reaches age 23 or no longer qualifies as a dependent before age 23, coverage will end on the last day of that month. Please see the Continuation and Individual Portability Policy sections for information on other coverage options.

CONTINUATION OF INSURANCE

Under federal and state laws, you and your family members may have the right to continue this plan's coverage for a specified time. You and your dependents may be eligible if:

- Your employment ends or you have a reduction in hours

- You take a leave of absence for military service
- You divorce or become legally separated
- You die
- You become eligible for Medicare benefits if it causes a loss of coverage for your dependents
- Your children no longer qualify as dependents

The following sections describe your rights to continuation under state and federal laws, and the requirements you must meet to enroll in continuation coverage.

USERRA CONTINUATION

If you take a leave of absence from your job due to military service, you have continuation rights under the Uniformed Services Employment and Re-employment Rights Act (USERRA).

You and your enrolled family members may continue this plan's coverage if you, the employee, no longer qualify for coverage under the plan because of military service. Continuation coverage under USERRA is available for up to 18 months while you are on military leave. If your military service ends and you do not return to work, your eligibility for USERRA continuation coverage will end. Premium for continuation coverage is your responsibility.

The following requirements apply to USERRA continuation:

- Family members who were not enrolled in the group plan cannot take continuation. The only exceptions are newborn babies and newly acquired dependents not covered by another group health plan.
- To apply for continuation, you must submit a completed Continuation Election Form to your employer within 31 days after the last day of coverage under the group plan.
- You must pay continuation premium to your employer by the first of each month. Your employer will include your continuation premium in the group's regular monthly payment. PacificSource cannot accept the premium directly from you.
- Your employer must still be insured by PacificSource. If your employer discontinues this plan, you will no longer qualify for continuation.

SURVIVING, DIVORCED, OR SEPARATED SPOUSES

If your group has 20 or more employees, and you die, divorce, or legally separate, and your spouse is 55 or older, your spouse may be able to continue coverage until eligible for Medicare or other coverage. Dependent children are subject to the group policy's age and other eligibility requirements. Some restrictions and guidelines apply; please see your employer for specific details.

COBRA CONTINUATION

If your employer group has 20 or more employees and is not an association group, church, or branch of the federal government, you have continuation rights under federal COBRA continuation laws. Local governments also have similar continuation rights under the Public Health Service Act.

COBRA Eligibility

A "qualifying event" is the event that causes your regular group coverage to end and makes you eligible for continuation coverage. When the following qualifying events happen, you may continue coverage for the lengths of time shown:

Qualifying Event	Continuation Period
Employee's termination of employment or reduction in hours	Employee, spouse, and children may continue for up to 18 months[1]
Employee's divorce or legal separation	Spouse and children may continue for up to 36 months[2]
Employee's eligibility for Medicare benefits if it causes a loss of coverage	Spouse and children may continue for up to 36 months
Employee's death	Spouse and children may continue for up to 36 months[2]
Child no longer qualifies as a dependent	Child may continue for up to 36 months[2]

[1] If the employee or covered dependent is determined disabled by the Social Security Administration within the first 60 days of COBRA coverage, all qualified beneficiaries may continue coverage for up to 29 months.

[2] The total maximum continuation period is 36 months, even if there is a second qualifying event. A second qualifying event might be a divorce, separation, death, or child no longer qualifying as a dependent after the employee's termination or reduction in hours.

If your dependents were not covered prior to your qualifying event, they may enroll in the continuation coverage while you are on continuation. They will be subject to the same rules that apply to active employees, including the late enrollment waiting period.

If your employment is terminated for gross misconduct, you and your dependents are not eligible for COBRA continuation.

When Continuation Coverage Ends

Your continuation coverage will end before the end of the continuation period above if any of the following occur:

- Your continuation premium is not paid on time.
- You become covered under another group health plan that does not exclude or limit treatment for your pre-existing conditions.
- You become entitled to Medicare benefits.
- Your employer discontinues its health plan and no longer offers a group health plan to any of its employees.
- Your continuation period was extended from 18 to 29 months due to disability, and you are no longer considered disabled.

When COBRA continuation coverage ends, you may be eligible to purchase an individual portability policy. Please see the Individual Portability Policy section for more information.

Type of Coverage

Under COBRA, you may continue any coverage you had before the qualifying event. If your employer provides both medical and dental coverage and you were enrolled in both, you may continue both medical and dental. If your employer provides only one type of coverage, or if you were enrolled in only one type of coverage, you may continue only that coverage.

COBRA continuation benefits are always the same as your employer's current benefits. Your employer has the right to change the benefits of its health plan or eliminate the plan entirely. If that happens, any changes to the group health plan will also apply to everyone enrolled in continuation coverage.

Your Responsibilities and Deadlines

You must notify your employer within 60 days if you divorce or legally separate, or if your child no longer qualifies as a dependent. That will allow your employer to notify you or your dependents of your continuation rights.

When your employer learns of your eligibility for continuation, your employer or COBRA Administrator will notify you of your continuation rights and provide a Continuation Election Form. You then have 60 days from that date or 60 days from the date coverage would otherwise end, whichever is later, to enroll in continuation coverage by submitting a completed Election Form to your employer or COBRA Administrator. If continuation coverage is not elected during that 60-day period, coverage will end on the last day of the last month you were an active employee.

If you or your employer do not provide these notifications within the time frames required by COBRA, PacificSource's responsibility to provide coverage under the group policy will end.

Continuation Premium

You or your family members are responsible for the full cost of continuation coverage. The monthly premium must be paid to a designated COBRA Administrator; PacificSource cannot accept continuation premium directly from you. You may make your first premium payment any time within 45 days after you return your Continuation Election Form to your employer or COBRA Administrator. After the first premium payment, each monthly payment must reach your employer or COBRA Administrator within 30 days of your employer's premium due date. If your employer or COBRA Administrator does not receive your continuation premium on time, continuation coverage will end. If your coverage is canceled due to a missed payment, it will not be reinstated for any reason. Premium rates are established annually and may be adjusted if the plan's benefits or costs change.

Labor Unions

If you are a union member, you have certain continuation rights in the event of a labor strike. Your union is responsible for collecting your premium and can answer questions about coverage during the strike.

CONTINUATION WHEN YOU RETIRE

If you retire, you and your insured dependents are eligible to continue coverage subject to the following:

- You must apply for continued coverage within 60 days after retirement.
- You must be receiving benefits for PERS (Public Employee Retirement System) or from a similar retirement plan offered by the group.

You and your eligible dependents have the same open enrollment and special enrollment options as do active employees.

Your continuation coverage will end when any one of the following occurs:

- When full premium is not paid or when your coverage is voluntarily terminated, your coverage will end on the last day of the month for which premium was paid.

- When you become eligible for federal Medicare coverage, your coverage will end on the last day of the month preceding the date you become eligible.
- When the regular group policy is terminated, your coverage will end on the date of termination.

Your dependent's continuation coverage will end when any one of the following occurs:

- When full premium for the dependent is not paid or when the dependent's coverage is voluntarily terminated by you or the dependent, coverage will end on the last day of the month for which premium was paid.
- When the dependent becomes eligible for federal Medicare coverage, coverage will end on the last day of the month of preceding Medicare eligibility.
- When your dependent child marries, reaches age 18, or is otherwise no longer considered a dependent under the group plan, his or her coverage will end on the last day of the month of their eligibility.
- When the regular group policy is terminated, your dependent's coverage will end on the date of termination.

INDIVIDUAL PORTABILITY POLICY

When coverage under this policy ends, you may be able to purchase a PacificSource individual portability policy. If you are eligible, you may purchase the policy when you lose coverage under this plan, or during your continuation coverage, or as soon as continuation coverage ends. In order to be eligible for the portability policy:

- You must live in Oregon.
- You must have been covered by this plan for at least six months (or by a combination of this plan and another Oregon group health benefit plan with no break in coverage).
- You must apply for the portability policy within 63 days after coverage under this plan or your continuation coverage ends.
- You must pay the premium to PacificSource on time each month.

You are not eligible to purchase a portability policy if you are eligible for this or any other plan provided by your employer, or are covered under another health plan, or are eligible for Medicare. For information on PacificSource individual portability policies, contact our Individual Sales Department at (541) 684-5585 or (877) 657-9797.

COVERED EXPENSES

This plan provides comprehensive medical coverage when care is medically necessary to treat an illness or injury. Be careful--just because a treatment is prescribed by a healthcare professional does not mean it is medically necessary under PacificSource guidelines. Also remember that just because a service or supply is a covered benefit under this plan does not necessarily mean PacificSource will pay all charges.

Some medically necessary services and supplies may be excluded from coverage under this plan. Be sure you read and understand the Benefit Limitations and Exclusions section of this book, including the section on Preauthorization. If you ever have a question about your plan benefits, contact the PacificSource Customer Service Department.

Medical Necessity

"Medically necessary" means services and supplies required for diagnosis or treatment of illness or injury that, in the judgment of PacificSource, are:

- Consistent with the symptoms or diagnosis and treatment of the condition
- Consistent with standards of good medical practice
- As likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply
- Not for your, your family member's, or your provider's convenience
- The least costly method of medical service which can be safely provided

Services and supplies intended to diagnose or screen for a medical condition are not considered medically necessary in the absence of signs or symptoms of the condition, or abnormalities on prior testing.

Your Annual Out-of-Pocket Limit

This plan has an out-of-pocket limit provision to protect you from excessive medical expenses. The Member Benefit Summary shows your plan's annual out-of-pocket limits for participating and/or nonparticipating providers. If you incur covered expenses over those amounts, this plan will pay 100 percent of eligible charges, subject to the allowable fee.

Your expenses for the following do not count toward the annual out-of-pocket limit:

- Prescription drugs
- Charges over the allowable fee for services of nonparticipating providers
- Incurred charges that exceed amounts allowed under this plan
- Charges of an Alternative Care provider

Prescription drug benefits are not affected by the out-of-pocket or stoploss limit. You will still be responsible for that copayment or coinsurance payment even after the out-of-pocket or stoploss limit is reached.

PLAN BENEFITS

This plan provides benefits for the following services and supplies as outlined on your Member Benefit Summary. These services and supplies may require you to satisfy a deductible, make a copayment, or both, and they may be subject to additional limitations or maximum dollar amounts. For a medical expense to be eligible for payment, you must be covered under this plan on the date the expense is incurred. Please refer to the Member Benefit Summary and the Benefit Limitations and Exclusions section of this handbook for more information.

PREVENTIVE CARE SERVICES

This plan covers the following preventive care services when provided by a physician, physician assistant, or nurse practitioner:

- **Routine physicals** for everyone over two years old according to the following schedule:
  - Ages 2-6: One exam per year
  - Ages 7-18: One exam every two years
  - Ages 19-34: One exam every four years
  - Ages 35-59: One exam every two years
  - Ages 60 and over: One exam every year

  Routine physical exams may include routine lab work and other diagnostic testing procedures ordered by your practitioner in connection with the exam
- One **routine gynecological exam** each calendar year for women 18 and over. Exams may include Pap smear, pelvic exam, breast exam, blood pressure check, and weight check. Exams may also include an annual mammogram for women 35 and over, or as recommended by a physician for women with a high-risk condition. Covered lab services are limited to occult blood, urinalysis, and complete blood count.
- One routine **hearing exam** in any 24-month period for dependent children through age 18 when provided by the dependent's primary care physician.
- One **routine eye exam** in a 24-month period for children through age 18 when provided by a physician or optometrist.
- **Well baby care**, including any appropriate lab services, as follows:
  - One in-hospital exam at birth
  - Six more exams during the first year of life
  - Two exams during the second year of life
- **Immunizations**, limited to the following:
  - Diphtheria, pertussis, and tetanus (DPT) vaccines
  - Polio vaccine
  - Measles, mumps, and rubella (MMR) vaccines
  - Hemophilus influenza B vaccine
  - Hepatitis A vaccine for the following members:
    - Children ages 2 through 18
    - Adults over age 18 only if there is a history of Hepatitis C
  - Hepatitis B vaccine
  - Pneumococcal vaccine for all children through age 2, and for those at high risk through age 4
  - Varicella vaccine (chicken pox)
  - Influenza vaccine, subject to limitations

PROFESSIONAL SERVICES

This plan covers the following professional services when medically necessary:

- Services of a **physician** (M.D. or D.O.) for diagnosis or treatment of illness or injury

- Services of a licensed **physician assistant** under the supervision of a physician
- Services of a certified **surgical assistant, surgical technician, or registered nurse** (R.N.) when providing medically necessary services as a surgical first assistant during a covered surgery
- Services of a **nurse practitioner**, including certified registered nurse anesthetist (C.R.N.A.) and certified nurse midwife (C.N.M.), for medically necessary diagnosis or treatment of illness or injury
- **Urgent care services** provided by a physician. “Urgent care” means services for an unforeseen illness or injury that requires treatment within 24 hours to prevent serious deterioration of a patient’s health. Urgent conditions are normally less severe than medical emergencies. Examples of conditions that could need urgent care are sprains and strains, vomiting, cuts, and severe headaches.
- Physical or occupational therapy provided by a licensed **physical therapist, occupational therapist, or physician**. Services must be prescribed in writing by a licensed physician, dentist, podiatrist, nurse practitioner, or physician assistant. The prescription must include site, modality, duration, and frequency of treatment. Total covered expense for combined services for physical, occupational, and speech therapy and pulmonary rehabilitation (see Speech Therapy and Pulmonary rehabilitation) physical and occupational therapy combined is limited to 30 visits in any 12-month period beginning with the first date of service. If rehabilitative services are required following head, spinal cord injury, or a cerebral vascular accident (stroke), 60 sessions in a 12-month period may be allowed.

  Coverage of additional visits requires preauthorization, and will only be considered for active, rehabilitative, goal-specific programs to restore or compensate for lost function for acute conditions. Functional capacity evaluations, work hardening, vocational rehabilitation, driving evaluations and training programs, community reintegration, and motion analysis are not covered services.
- Services of a physician or a licensed certified nurse midwife for **pregnancy**. Services are subject to the same payment amounts, conditions, and limitations that apply to similar expenses for illness, except that pregnancy is not considered a pre-existing condition. Please contact the PacificSource Customer Service Department as soon as you learn of your pregnancy. Our staff will explain your plan’s maternity benefits and help you enroll in our free prenatal care program.
- **Routine nursery care** of a newborn while the mother is hospitalized and eligible for pregnancy-related benefits under this plan
- Services of a certified speech therapist for medically necessary **speech therapy**, limited to a combined 30 sessions in a 12-month period for physical, occupational, and speech therapy and pulmonary rehabilitation (see Physical or occupational Therapy and Pulmonary rehabilitation). Services require preauthorization by PacificSource, and will only be allowed when needed to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological disease or injury. Speech therapy for developmental language and phonological disorders is only considered medically necessary for patients at least 2 ½ years old who are unable to communicate basic needs. The plan does not cover speech therapy for learning disorders or oral/facial motor therapy for strengthening and coordination of speech-producing muscles and structures.
- Services of a licensed audiologist for medically necessary **audiological (hearing) tests**.
- Services of a dentist or physician to treat **injury of the jaw or natural teeth**. Services must be provided within 180 days of the injury.

- Services of a dentist or physician for **orthognathic (jaw) surgery** as follows:
  - — When medically necessary to repair an accidental injury. Services must be provided within one year after the accident.
  - — For removal of a malignancy, including reconstruction of the jaw within one year after that surgery
- Services of a board-certified or board-eligible **genetic counselor** when referred by a physician or nurse practitioner for evaluation of genetic disease
- **Infertility services** are covered when medically necessary subject to a 50 percent copayment. In vitro fertilization and procedures determined to be experimental or investigational in nature are not covered (see Excluded Services section).
- Treatment of **temporomandibular joint syndrome** (TMJ) for medical reasons only. All TMJ-related services, including but not limited to diagnostic and surgical procedures (see preauthorization). Services are covered only when medically necessary due to a history of advanced pathologic process (arthritic degeneration) or in the case of severe acute trauma. Benefits for the treatment of TMJ and all related services are limited to 50 percent of eligible charges.
- Service of a **podiatrist** for non-routine foot care when authorized by a Primary Care Practitioner.
- Services of a **naturopath** for medically necessary diagnosis and treatment of illness or injury. See Alternative Care Benefit Summary for additional information.
- **Acupuncture** services of a licensed acupuncturist or physician when necessary for diagnosis and treatment of illness or injury. See Alternative Care Benefit Summary for additional information.
- Covered **chiropractic** expenses are the reasonable and medically necessary charges of a licensed chiropractor for the treatment of bone, muscle, and joint disorders through manipulation of the spine and related supporting services including lab and x-ray. See Alternative Care Benefit Summary for additional information.
- Services of a licensed **massage therapist**. See Alternative Care Benefit Summary for additional information.

HOSPITAL AND SKILLED NURSING FACILITY SERVICES

This plan covers medically necessary **hospital inpatient services**. Charges for a hospital room are covered up to the hospital's semi-private room rate (or private room rate, if the hospital does not offer semi-private rooms). Charges for a private room are covered if the attending physician orders hospitalization in an intensive care unit, coronary care unit, or private room for medically necessary isolation.

In addition to the hospital room, covered inpatient hospital services may include (but are not limited to):

- Cardiac care unit
- Operating room
- Anesthesia and post-anesthesia recovery
- Respiratory care

- Inpatient medications
- Lab and radiology services
- Dressings, equipment, and other necessary supplies

The plan does not cover charges for rental of telephones, radios, or televisions, or for guest meals or other personal items.

Special Information about Childbirth - PacificSource covers hospital inpatient services for childbirth according to the Newborns' and Mothers' Health Protection Act of 1996. This plan does not restrict the length of stay for the mother or newborn child to less than 48 hours after vaginal delivery, or to less than 96 hours after Cesarean section delivery. Your provider is allowed to discharge you or your newborn sooner than that, but only if you both agree. For childbirth, your provider does not need to preauthorize your hospital stay with PacificSource.

Services of a **skilled nursing facility** are covered for up to 60 days per calendar year when preauthorized by PacificSource. Confinement for dementia, mental illness, or custodial care is not covered.

This plan covers **inpatient rehabilitative care** up to 30 days in a 12-month period (see preauthorization requirements). If rehabilitative services are required following head, spinal cord injury, or a cerebral vascular accident (stroke), 60 days in a 12-month period may be allowed.

OUTPATIENT SERVICES

This plan covers the following outpatient care services:

- Diagnostic **CT scans and MRIs**. When services are provided as part of a covered emergency room visit, your plan's emergency room benefit applies. In all other situations and settings, the benefit shown on your Member Benefit Summary for Outpatient Services - CT Scans and MRIs applies.
- Diagnostic **radiology and laboratory procedures** provided or ordered by a physician, nurse practitioner, or physician assistant. These services may be performed or provided by laboratories, radiology facilities, hospitals, and physicians, including services in conjunction with office visits.
- **Emergency room services**. The emergency room copayment shown on your Member Benefit Summary covers medical screening and any diagnostic tests needed for emergency care, such as radiology, laboratory work, CT scans, and MRIs. The copayment does not cover further treatment provided on referral from the emergency room.

  Emergency room charges for services, supplies, or conditions excluded from coverage under this plan are not eligible for payment. That includes conditions subject to the plan's reduced benefit periods for pre-existing and other conditions. Please see the Benefit Limitations and Exclusions section of this handbook.
- **Surgery** and other outpatient services. Benefits are based on the setting where services are performed.
  - For surgeries or outpatient services performed in a physician's office, your plan's Professional Services - Office Visit benefit applies.
  - For surgeries or outpatient services performed in an ambulatory surgery center or outpatient hospital setting, both the Professional Services - Surgery and the Outpatient Services - Outpatient Surgery/Services benefits apply.

- Therapeutic **radiology services, chemotherapy, and renal dialysis** provided or ordered by a physician

EMERGENCY SERVICES

In a true medical emergency, this plan covers services and supplies necessary to determine the nature and extent of the emergency condition and to stabilize the patient.

An emergency medical condition is an injury or sudden illness, including severe pain, so severe that a prudent layperson with an average knowledge of health and medicine would expect that failure to receive immediate medical attention would risk seriously damaging the health of a person or fetus in the case of a pregnant woman. Examples of emergency medical conditions include (but are not limited to):

- Unusual or heavy bleeding
- Sudden abdominal or chest pains
- Suspected heart attacks
- Major traumatic injuries
- Serious burns
- Poisoning
- Unconsciousness
- Convulsions or seizures
- Difficulty breathing
- Sudden fevers

If you need immediate assistance for a medical emergency, call 911. If you have an emergency medical condition, you should go directly to the nearest emergency room or appropriate facility. Care for a medical emergency is covered at the participating provider percentage shown on your Member Benefit Summary even if you are treated at a nonparticipating hospital. If you are admitted to a nonparticipating hospital after your emergency condition is stabilized, PacificSource may require you to transfer to a participating facility in order to continue receiving benefits at the participating provider level.

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

This plan covers medically necessary crisis intervention, diagnosis, and treatment of mental health conditions and chemical dependency. Refer to the Benefit Limitations and Exclusions section of this handbook for more information on services not covered by your plan.

Only the following providers of mental health and chemical dependency services are eligible for reimbursement:

- Licensed medical or osteopathic physicians (M.D. or D.O.), including psychiatrists, licensed psychologists (Ph.D.) and psychology associates, registered nurse practitioners (N.P.), and licensed clinical social workers (L.C.S.W.).
- Programs licensed by a state mental health division for alcoholism, chemical dependency, or mental disturbance.
- Hospitals and other facilities licensed for inpatient or residential treatment of mental health conditions or chemical dependency.

Covered Mental Health and Dual Diagnosis Services

This plan covers the following mental health services:

- Assessment and evaluation to make a definitive diagnosis of a mental disorder
- Treatment provided in hospital inpatient facilities, residential programs or facilities, day or partial hospitalization programs, or outpatient services. Treatment in inpatient and residential settings requires preauthorization by PacificSource.
- Treatment of dual diagnosis. Dual diagnosis means a condition involving both mental health and chemical dependency which requires the simultaneous treatment of both conditions. For dual diagnosis conditions, the facility or program must be accredited for treatment of dual diagnosis, and services must be preauthorized by PacificSource.

Benefits for treatment for mental health and dual diagnosis conditions are limited to the following maximums in any 24-month period, beginning with the first day of service:

Adults 18 and older:

Inpatient	16 days
Residential	27 days
Outpatient	36 visits

Children 17 and younger:

Inpatient	17 days
Residential	27 days
Outpatient	36 visits

Covered Chemical Dependency Services

Chemical dependency means the addictive relationship with alcohol or any drug. Chemical dependency is characterized by a physical or psychological relationship, or both, that interferes with the person's social, psychological, or physical adjustment to common problems on a recurring basis. Chemical dependency does not include addiction to, or dependency on, tobacco or food.

For chemical dependency, this plan covers treatment provided in hospital inpatient facilities, residential programs or facilities, day or partial hospitalization programs, or outpatient services. Treatment in inpatient and residential settings requires preauthorization by PacificSource.

Benefits for treatment of chemical dependency are limited to the following maximums in any 24-month period, beginning with the first day of service:

Adults 18 or older:

Inpatient	14 days
Residential	21 days
Outpatient	27 visits

Children 17 or younger:

Inpatient	32 days
Residential	30 days
Outpatient	39 visits

Preauthorization and Review Requirements

- Coverage of all inpatient and residential treatment requires preauthorization by PacificSource. Only emergency admissions are covered without prior approval, and then PacificSource must be notified within 48 hours.
- Coverage of outpatient mental health treatment does not require preauthorization. However, ongoing outpatient treatment may be subject to review to determine if continued treatment is medically necessary.
- Medication management by an M.D. (such as a psychiatrist) does not require review.

Transfer or Extension of Benefits

The benefits shown above for mental health, dual diagnosis, and chemical dependency treatment include the maximum benefits available for each treatment category (inpatient, residential, and outpatient). Unused benefits in one treatment category cannot be transferred to another treatment category, and these benefits cannot be extended for any reason.

HOME HEALTH AND HOSPICE SERVICES

- This plan covers **home health services** when preauthorized by PacificSource. Covered services include skilled nursing by a R.N. or L.P.N.; physical, occupational, and speech therapy; and medical social work services provided by a licensed home health agency. Private duty nursing is not covered.
- **Home infusion services** are covered when preauthorized by PacificSource. This benefit covers parenteral nutrition, medications, and biologicals (other than immunizations) that cannot be self-administered. Benefits are paid at the percentage shown on your Member Benefit Summary for home health care.
- This plan covers **hospice services** when preauthorized by PacificSource. Hospice services are intended to meet the physical, emotional, and spiritual needs of the patient and family during the final stages of illness and dying, while maintaining the patient in the home setting. Services are intended to supplement the efforts of an unpaid caregiver. Hospice care benefits are limited to a lifetime maximum of $15,000 per member. If the member elects to discontinue hospice care before the benefit maximum is exhausted, the member will forfeit any remaining hospice benefit. Hospice does not provide services of a primary caregiver such as a relative or friend, and private duty nursing is not a covered benefit. PacificSource uses specific criteria to determine eligibility for hospice benefits. For more information, please contact PacificSource Customer Service.

TRANSPLANT SERVICES

This plan covers certain medically necessary organ and tissue transplants. It also covers the cost of acquiring organs or tissues needed for covered transplants and limited travel expenses for the patient, subject to certain limitations.

All pretransplant evaluations, services, treatments, and supplies for transplant procedures require preauthorization by PacificSource. Also, you must have been covered under this plan for at least 24 consecutive months or since birth to be eligible for transplant benefits, including benefits for transplantation evaluation. See Exclusion Periods - Transplants in the Benefit Limitations and Exclusions section of this handbook for details.

This plan covers the following medically necessary organ and tissue transplants:

- Kidney

- Kidney – Pancreas
- Pancreas whole organ transplantation (under certain criteria)
- Heart
- Heart - Lung
- Lung
- Liver (under certain criteria)
- Bone marrow and peripheral blood stem cell
- Pediatric bowel

This plan only covers transplants of human body organs and tissues. Transplants of artificial or animal organs and tissues are not covered. Travel and living expenses are not covered for the recipient's family members or the donor, and travel and housing expenses for the recipient are limited to $5,000.

For detailed transplant criteria, please see the group policy or contact the PacificSource Customer Service Department.

Payment of Transplant Benefits

If a transplant is performed at a participating transplantation facility, covered charges of the facility are paid in full. If our contract with the facility includes the services of the medical professionals performing the transplant (such as physicians, nurses, and anesthesiologists), those charges are also paid in full. If the professional fees are not included in our contract with the facility, then those benefits are provided according to your Member Benefit Summary.

If transplant services are available through a contracted transplantation facility but are not performed at a contracted facility, you are responsible for satisfying any deductibles or copayments shown on your Member Benefit Summary. This plan then pays 50 percent of the billed amount. Services of nonparticipating medical professionals are paid at the nonparticipating provider percentages shown on the Member Benefit Summary.

OTHER COVERED SERVICES, SUPPLIES, AND TREATMENTS

- This plan covers services of a state certified **ambulance** when private transportation is inappropriate because a medical condition requires paramedic support. Benefits are provided for emergency ambulance service to the nearest facility able to treat the condition. Air transportation is also covered, but only when ground transportation is medically or physically inappropriate.
- This plan covers **biofeedback** to treat migraine headaches or urinary incontinence when provided by an otherwise eligible practitioner. Benefits are limited to a lifetime maximum of 10 sessions.
- This plan covers **blood transfusions**, including the cost of blood or blood plasma.
- This plan covers removal, repair, or replacement of an internal **breast prosthesis** due to a contracture or rupture, but only when the original prosthesis was for a medically necessary mastectomy. Preauthorization by PacificSource is required, and eligibility for benefits is subject to PacificSource's criteria. PacificSource may require a signed loan receipt/subrogation agreement before providing coverage for this benefit. Please contact PacificSource Customer Service for more information.

- **Breast reconstruction** with or without prosthesis, including reconstruction of the opposite breast to achieve cosmetic symmetry, is covered after a medically necessary mastectomy.
- This plan covers **cardiac rehabilitation** as follows:
  - Phase I (inpatient) services are covered under inpatient hospital benefits.
  - Phase II (short-term outpatient) services are covered at the percentages on your Member Benefit Summary for outpatient hospital benefits. Preauthorization by PacificSource is required.
  - Phase III (long-term outpatient) services are not covered.
- This plan covers IUD, Norplant, diaphragm, and cervical cap **contraceptive devices** along with their insertion or removal. Contraceptive devices that can be obtained over the counter or without a prescription, such as condoms, contraceptive sponges, female condoms, and spermicides are not covered.
- This plan covers **corneal transplants**. Preauthorization is not required.
- In the following situations, this plan covers one attempt at **cosmetic or reconstructive surgery:**
  - When necessary to correct a functional disorder
  - When necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury
  - When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery
  - To correct congenital anomalies on children under age 18

  Cosmetic or reconstructive surgery must take place within 18 months after the injury, surgery, scar, or defect first occurred. Preauthorization by PacificSource is required for all cosmetic and reconstructive surgeries covered by this plan. For information on breast reconstruction, see “breast prosthesis” and “breast reconstruction” in this section.
- This plan provides coverage for certain **diabetic supplies and training** as follows:
  - Diabetic supplies other than insulin and syringes (such as lancets, test strips, and glucostix) are covered at the amount shown on your Member Benefit Summary for durable medical equipment. You may purchase those supplies from any retail outlet and send your receipts to PacificSource, along with your name, group number, and member ID number. We will process the claim and mail you a reimbursement check.
  - Diabetic insulin and syringes are covered under your prescription drug benefit, if your plan includes prescription coverage.
  - The plan covers one diabetes self-management education program at the time of diagnosis, and up to three hours of education per year if there is a significant change in your condition or its treatment. To be covered, the training must be provided by an accredited diabetes education program, or by a physician, registered nurse, nurse practitioner, certified diabetes educator, or licensed dietitian with expertise in diabetes.
- This plan covers **dietary or nutritional counseling** provided by a registered dietitian under certain circumstances. It is covered under the diabetic education benefit, or for management of inborn errors of metabolism (excluding obesity), or for management of anorexia nervosa or bulimia nervosa (to a lifetime maximum of five visits), or under your Alternative Care benefit (see Alternative Care Benefit Summary for additional information).

- This plan covers **durable medical equipment** prescribed exclusively to treat medical conditions up to an annual maximum of $5,000. Covered equipment includes crutches, wheelchairs, orthopedic braces, home glucose meters, equipment for administering oxygen, and non-power assisted prosthetic limbs and eyes. Durable medical equipment must be prescribed by a licensed M.D., D.O., N.P., P.A., D.D.S., D.M.D., or D.P.M. to be covered. This plan does not cover equipment commonly used for nonmedical purposes, for physical or occupational therapy, or prescribed primarily for comfort. Please see "Excluded Services - Equipment and Devices" in the Benefit Limitations and Exclusions section for information on items not covered.

  This benefit covers the cost of either purchase or rental of the equipment for the period needed, whichever is less. Repair or replacement of equipment is also covered when necessary. If the cost of the purchase, rental, repair, or replacement is over $500, preauthorization by PacificSource is required.

  Purchase, rental, or lease of a power-assisted wheelchair (including batteries and other accessories) is covered up to a maximum benefit of $5,000. Benefits for a power-assisted wheelchair are available in place of, not in addition to, benefits for a manual wheelchair.

  The durable medical equipment benefit also covers lenses to correct a specific vision defect resulting from a severe medical or surgical problem, such as stroke, neurological disease, trauma, or eye surgery other than refraction procedures. Coverage is subject to specific criteria, and this benefit is subject to limitations including a $200 maximum allowance for lenses and frames. Please contact PacificSource Customer Service for more information.

- This plan covers nonprescription **elemental enteral formula** ordered by a physician for home use. Formula is covered when needed to treat severe intestinal malabsorption. Coverage is provided at the amount shown on your Member Benefit Summary for durable medical equipment.
- This plan covers routine **foot care** for patients with diabetes mellitus.
- This plan covers medically necessary **foot orthotics**, including related charges for evaluation and casting. Foot orthotics must be custom made or fitted and prescribed by a by a licensed physician or podiatrist to be covered.
- This plan provides a 50 percent benefit for **hearing aids,** subject to a limit of a $1000 maximum in any 36-month period. Charges for fitting, internal or external placement or replacement (including implanted hearing aids or implant procedures) are not covered.
- **Hospitalization for dental procedures** is covered when the patient has another serious medical condition that may complicate the dental procedure, such as serious blood disease, unstable diabetes, or severe cardiovascular disease, or when a major dental procedure is necessary, such as a multiple extraction or removal of impacted teeth or oral tumors. Coverage requires preauthorization by PacificSource, and only charges for the facility, anesthesiologist, and assistant physician are covered. Hospitalization because of the patient's apprehension or convenience is not covered.
- **Injectable drugs and biologicals** administered by a physician are covered when medically necessary for diagnosis or treatment of illness or injury. This benefit does not include immunizations (see Preventive Care Services in this section) or drugs or biologicals that can be self-administered or are dispensed to a patient.

- This plan covers **maxillofacial prosthetic services** when prescribed by a physician as necessary to restore and manage head and facial structures. Coverage is provided only when head and facial structures cannot be replaced with living tissue, and are defective because of disease, trauma, or birth and developmental deformities. To be covered, treatment must be necessary to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing. Coverage is limited to the least costly clinically appropriate treatment, as determined by the physician. Cosmetic procedures and procedures to improve on the normal range of functions are not covered. Dentures and artificial larynx are also not covered.
- This plan covers treatment for inborn errors of **metabolism** involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring. Nutritional supplies are covered at the amount shown on your Member Benefit Summary for durable medical equipment.
- For **pediatric dental care** for children under the age of six (6) years requiring general anesthesia, this plan covers the facility charges of a hospital or ambulatory surgery center. Professional charges for the dentist and anesthesiologist are not covered. Preauthorization by PacificSource is required.
- Outpatient **pulmonary rehabilitation** programs are covered for patients with severe chronic lung disease that interferes with normal daily activities despite optimal medication management. A limit of 30 visits in a 12-month period applies to combined services for physical, occupational, and speech therapy and pulmonary rehabilitation (see Physical/Occupational and Speech Therapy). A physician's prescription and preauthorization by PacificSource are required.
- Medically necessary treatment for **sleep apnea and other sleeping disorders** is covered when preauthorized by PacificSource. Coverage of oral devices includes charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a physician specializing in evaluation and treatment of obstructive sleep apnea, and the condition must meet criteria for obstructive sleep apnea.
- **Sleep studies** are covered when ordered by a pulmonologist, neurologist, otolaryngologist, or certified sleep medicine specialist, and when performed at a certified sleep laboratory.
- This plan covers **tubal ligation and vasectomy** procedures.

BENEFIT LIMITATIONS AND EXCLUSIONS

Least Costly Setting for Services

Covered services must be performed in the least costly setting where they can be provided safely. If a procedure can be done safely in an outpatient setting but is performed in a hospital inpatient setting, this plan will only pay what it would have paid for the procedure on an outpatient basis. If services are performed in an inappropriate setting, your benefits can be reduced by up to 30 percent or $2,500, whichever is less.

Maximum Lifetime Benefit

The maximum lifetime benefit on your Member Benefit Summary is the total amount PacificSource will pay for any person's medical expenses during their lifetime. Your lifetime maximum benefit is like an account, and it works like this:

- Each time we pay benefits for your care, we deduct that amount from your lifetime maximum benefit account.

- If you were insured under another PacificSource policy before this plan, the amount we paid for your care under that policy is subtracted from your lifetime maximum account under this plan.
- For each calendar year you are covered, we add an amount back into your lifetime maximum account. If your covered expenses for the year totaled $50,000 or less, then on January 1 we restore the full amount of your covered expenses for the previous year. If your covered expenses for the year were over $50,000, then we restore $50,000 to your account.

EXCLUDED SERVICES

A Note About Optional Benefits

If your employer provides coverage for optional benefits such as prescription drugs, vision services, chiropractic care, or alternative care, you'll find those Member Benefit Summaries in this handbook. If your employer provides optional benefits for an exclusion listed below, then the exclusion does not apply to the extent that coverage exists under the optional benefit. For example, if your employer provides optional chiropractic coverage, then the exclusion for chiropractic care listed below under "Types of Treatment" does not apply to you.

This is only a summary of excluded services, supplies, and expenses. For details, please refer to the General Exclusions section of your group health policy.

Types of Treatment - This plan does not cover the following:

- Biofeedback other than for migraine headaches or urinary incontinence, which is limited to 10 sessions
- Chelation therapy, unless preauthorized by PacificSource for certain medical conditions or heavy metal toxicities
- Day care or custodial care, including help with daily activities such as walking, getting in or out of bed, bathing, dressing, eating, and preparing meals
- Dental examinations and treatment, which means any services or supplies to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures
- Eye examinations (routine)
- Family planning services and supplies other than sterilization
- Fitness or exercise programs and health or fitness club memberships
- Foot care (routine), unless you are being treated for diabetes mellitus. Routine foot care includes services and supplies for corns and calluses, toenail conditions other than infection, and hypertrophy or hyperplasia of the skin of the feet
- Genetic (DNA) testing, except for tests identified by PacificSource as medically necessary for the diagnosis and standard treatment of specific diseases
- Homeopathic treatment
- Infertility - Services or supplies to diagnose, prevent, or treat sterility, infertility, impotency, frigidity, or sexual dysfunction
- Instructional or educational programs, except diabetes self-management programs
- Jaw - Services or supplies for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, or improving placement of dentures

- Massage, massage therapy, or neuromuscular re-education, even as part of a physical therapy program
- Maternity care for surrogate mothers
- Motion analysis, including physician review
- Myeloablative high dose chemotherapy, except when the related transplant is covered
- Obesity (including all categories) or weight control treatment or surgery, even if there are other medical reasons for you to control your weight. Food supplementation programs, behavior modification and self-help programs, and other services and supplies for weight loss are also excluded from coverage.
- Osteopathic manipulation, except for treatment of disorders of the musculoskeletal system
- Physical or eye exams required for administrative purposes, such as participation in athletics, admission to school, or employment
- Physical or occupational therapy for developmental delays and disorders, sensory integration disorders, motor skills disorders, or learning disorders
- Private nursing service
- Programs that teach a person to use medical equipment, care for family members, or self-administer drugs or nutrition (except for the diabetic education benefit)
- Screening tests, imaging, and exams solely for screening, and not associated with a specific diagnosis, sign of disease, or abnormality on prior testing (except as allowed under the preventive care benefit). Also excluded are total body CT imaging, CT colonography, and bone density testing.
- Self-help or training programs
- Smoking cessation aids or treatment to modify tobacco use or promote general fitness
- Snoring - Services or supplies for the diagnosis or treatment of snoring or upper airway resistance disorders, including somnoplasty
- Speech therapy for developmental language disorders, phonological disorders, and learning disorders, and facial motor therapy for strengthening and coordination of speech-producing muscles and structures
- Vocational rehabilitation, functional capacity evaluations, work hardening programs, community reintegration services, and driving evaluations and training

Surgeries and Procedures - This plan does not cover the following:

- Abdominoplasty
- Artificial insemination, in vitro fertilization, or GIFT procedures
- Cosmetic or reconstructive services, except as specified in the Covered Expenses - Other Covered Services, Supplies, and Treatments section
- Eye refraction procedures, orthoptics, vision therapy, or other services to correct refractive error
- Jaw surgery – Treatment for abnormalities of the jaw, malocclusion, or improving the placement of dentures and dental implants
- Orthognathic surgery - Treatment to augment or reduce the upper or lower jaw, except for reconstruction due to an injury (see Covered Expenses - Professional Services)

- Panniculectomy
- Sex transformations
- Surgery to reverse voluntary sterilization
- Transplants, except as specified in the Covered Expenses - Transplants section

Mental Health Services - This plan does not cover the following services, whether provided by a mental health specialist or by any other provider:

- Diagnoses: Treatment of mental retardation, learning disorders, motor skills disorders, communication disorders, developmental delays and disorders, pervasive developmental disorders (such as autism), disruptive behavior disorders, factitious disorders, sexual and gender identity disorders, impulse control disorders, paraphilias (except for pedophilia, which is covered), relational problems, caffeine-related disorders, nicotine-related disorders, sensory integration disorders, and conduct disorders
- Types of treatment: Neurodevelopmental therapy, sensory integration training, biofeedback (other than as specifically noted under Covered Expenses – Other Covered Services, Supplies, and Treatments), hypnotherapy, academic skills training, narcosynthesis, and social skills training. Recreation therapy is only covered as part of a mental health inpatient or residential program.
- Adolescent wilderness treatment programs
- Counseling or training for career issues, personal growth, assertiveness, sensitivity, image therapy, relaxation, stress management, parenting skills, or family education
- Court-mandated diversion or chemical dependency education classes, court-mandated psychological evaluations for child custody cases, and mental evaluations to adjudicate legal rights
- Self-help or training programs, including programs to help stop smoking
- Sensory movement group therapy or marathon group therapy
- Sexual dysfunction - Psychological evaluation for sexual dysfunction or inadequacy
- Voluntary mutual support groups such as Alcoholics Anonymous
- Any mental health service unrelated to the treatment or diagnosis of a mental disorder
- Services of any provider not listed as eligible for reimbursement under the Covered Expenses - Mental Health and Chemical Dependency Services section

Drugs and Medications - This plan does not cover the following:

- Drugs and biologicals that can be self-administered (including injectibles), other than those provided in a hospital, emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered
- Growth hormone injections or treatments, except to treat documented growth hormone deficiencies
- Immunizations or other medications or supplies for protection while traveling or at work
- Over-the-counter medications or nonprescription drugs

Equipment and Devices - This plan does not cover the following:

- Computer or electronic equipment for monitoring asthmatic, diabetic, or similar medical conditions or related data

- Equipment commonly used for nonmedical purposes, or marketed to the general public, or prescribed primarily for comfort, or intended to alter the physical environment. This includes appliances like air conditioners, air purifiers, room humidifiers, heating and cooling pads, home blood pressure monitoring equipment, light boxes, conveyances other than conventional wheelchairs, whirlpool baths, spas, saunas, heat lamps, tanning lights, and pillows. It also includes orthopedic shoes and shoe modifications. Mattresses and mattress pads are only covered when medically necessary to heal pressure sores.
- Equipment used for physical or occupational therapy, or used primarily in athletic or recreational activities. This includes exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal problems.
- Eyeglasses or contact lenses
- Hearing aids
- Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition
- Personal items such as telephones, televisions, and guest meals during a stay at a hospital or other inpatient facility

Experimental or Investigational Treatment

Your PacificSource plan does not cover experimental or investigational treatment. By that, we mean services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines or the use thereof that are, in PacificSource's judgment, experimental or investigational for the diagnosis and treatment of the patient. It includes treatment that, when and for the purpose rendered:

- Has not yet received full U.S. government agency approval (e.g. FDA) for other than experimental, investigational, or clinical testing;
- Is not of generally accepted medical practice in Oregon or as determined by PacificSource in consultation with medical advisors, medical associations, and/or technology resources;
- Is not approved for reimbursement by the Centers for Medicare and Medicaid Services;
- Is furnished in connection with research or clinical trials; or
- Is considered by any governmental agency or subdivision to be experimental or investigational, not reasonable and necessary, or any similar finding.

When making decisions about whether treatments are investigational or experimental, we rely on the above resources as well as:

- Expert opinions of specialists and other medical authorities;
- Published articles in peer-reviewed medical literature;
- External agencies whose role is the evaluation of new technologies and drugs; and
- External review by an independent review organization.

If you or your provider have any concerns about whether a course of treatment will be covered, we encourage you to contact our Customer Service Department. We will arrange for medical review of your case against our criteria, and notify you of whether the proposed treatment will be covered.

Other Items - This plan does not cover the following:

- Services or supplies that are not medically necessary in PacificSource's judgment

- Charges for inpatient stays that began before you were covered by this plan
- Services or supplies received before this plan's coverage began
- Services or supplies received after enrollment in this plan ends. (The only exception is that if this policy is replaced by another group health policy while you are hospitalized, PacificSource will continue paying covered hospital expenses until you are released or your benefits are exhausted, whichever occurs first.)
- Treatment of any illness or injury resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement authority
- Services or supplies available to you from another source, including those available through a government agency
- Services or supplies with no charge, or which your employer would have paid for if you had applied, or which you are not legally required to pay for. This includes services provided by yourself or an immediate family member.
- Charges that are the responsibility of a third party who may have caused the illness or injury or other insurers covering the incident (such as workers' compensation insurers, automobile insurers, and general liability insurers)
- Services or supplies for which you are not willing to release the medical information PacificSource needs to determine eligibility for payment
- Treatment of any condition caused by a war, armed invasion, or act of aggression, or while serving in the armed forces
- Treatment of any work-related illness or injury, unless your policy provides on-the-job health coverage by endorsement. This includes illness or injury caused by any for-profit activity, whether through employment or self-employment, regardless of the availability of workers' compensation.
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims
- Any amounts in excess of the allowable fee for a given service or supply
- Services of providers who are not eligible for reimbursement under this plan
- Any services or supplies not specifically listed as covered benefits under this plan

REDUCED BENEFIT PERIODS

Transplants

Except for corneal transplants, organ and tissue transplants are not covered until you have been enrolled in this plan for 24 months. If you were covered under another health insurance plan before enrolling in this plan, you can receive credit for your prior coverage. See Credit for Prior Coverage, below.

CREDIT FOR PRIOR COVERAGE

You can receive credit toward this plan's reduced benefit periods if you had qualifying healthcare coverage before enrolling in this plan. To qualify for this credit, there may not have been more than a 63-day gap between your last day of coverage under the previous health plan and your first day of coverage (or the first day of your employer's probationary waiting period) under this plan. Also, your prior coverage must have been a group health plan, individual health insurance plan (including student plans), Medicaid, Medicare, CHAMPUS, state health benefits risk pool, or public health plan. If you were covered as a dependent under a plan that meets these qualifications, you will qualify for credit. Many people elect the COBRA or state continuation coverage available under a prior plan to make sure they won't have more than a 63-day gap in coverage.

It is your responsibility to show you had creditable coverage. If you qualify for credit, PacificSource will count every day of coverage under your prior plan toward this plan's reduced benefit periods for pre-existing conditions and transplants (explained above).

Evidence of Prior Creditable Coverage

You can show evidence of creditable coverage by sending PacificSource a Certificate of Creditable Coverage from your previous health plan. All health plans, insurance companies, and HMOs are required by law to provide these certificates on request. Most insurers issue these certificates automatically whenever someone's coverage ends. The certificate shows how long you were covered under your previous plan and when your coverage ended.

If you do not have a certificate of prior coverage, contact your previous insurance company or plan sponsor (such as your former employer, if you had a group health plan). You have the right to request a certificate from any prior plan, insurer, HMO, or other entity through which you had creditable coverage. If you are unable to obtain a certificate, contact our Membership Services Department and we will assist you.

PREAUTHORIZATION

Coverage of certain medical services and surgical procedures requires PacificSource's written authorization before the services are performed. This process is called "preauthorization." Your medical provider can request preauthorization from the PacificSource Medical Affairs Department by phone, fax, mail, or e-mail. If your provider will not request preauthorization for you, you may contact us yourself. In some cases, we may ask for more information or require a second opinion before authorizing coverage.

Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. If your treatment is not preauthorized, you can still seek treatment, but you will be held responsible for the expense if it is not medically necessary or is not covered by this plan. Remember, any time you are unsure if an expense will be covered, contact the PacificSource Customer Service Department.

Because of the changing nature of medicine, PacificSource continually reviews new technologies and standards of medical practice. The list of procedures and services requiring preauthorization is therefore subject to revision and update. You'll find the most current preauthorization list on our Web site, www.pacificsource.com, under "For Members." The list of procedures and services requiring preauthorization includes, but is not limited to, the following:

- **Ambulance transports** (air or ground) between medical facilities, except in emergencies

- CT-scan measurements of **bone density**
- **Breast reconstruction,** including reduction and implants
- Outpatient **cardiac** (Phase II) and **pulmonary rehabilitation**
- **Chelation therapy**
- **Cosmetic and reconstructive procedures** including skin peels, scar revisions, facial plastic procedures or reconstruction, and procedures to remove superficial varicosities or other superficial vascular lesions
- **Durable medical equipment** expense over $500, including purchase, rental, repair, lease, or replacement, or rental for longer than three months
- **EBT or EBCT** (electron beam [computed] tomography)
- **Elective medical admissions**, such as preadmission, or admission to a hospital for diagnostic testing or procedures normally done in an outpatient setting, and **transfers to nonparticipating facilities**
- **Experimental or investigational** procedures or surgeries
- **Extensions** of previously authorized benefits, such as physical or occupational therapy
- **Gamma knife procedures**
- **Genetic (DNA) testing**
- **Home health**, outpatient and home IV infusion, and hospice services, and enteral nutrition supplies
- **Hospitalization for dental procedures** when covered under this plan, including pediatric dental procedures
- **Kidney dialysis**
- **Laparoscopies** of the female reproductive system
- **Mental health and chemical dependency** inpatient or residential treatment, including intensive outpatient mental health treatment
- Multidisciplinary **pain management** and rehabilitation evaluations and programs
- **PET scans**
- **Radiofrequency neurotomy**
- **Rehabilitation** or skilled nursing facility admissions
- Surgical procedures, supplies, and equipment for **sleep apnea and other sleeping disorders**
- **Speech therapy** services
- **Surgeries or procedures** in a hospital or ambulatory center during any reduced benefit period
- **Transplantation** of organ, bone marrow, and stem cells, including evaluations, related donor services, and HLA tissue typing. Preauthorization is not required for corneal transplants.
- **Varicose vein procedures**

If your (or your provider's) preauthorization request is approved, it is valid for 90 days. However, if your coverage under this plan ends before the service is performed, the preauthorization will become invalid.

If your (or your provider's) preauthorization request is denied and you believe the denial is inappropriate, you may appeal our decision. Please see Complaints, Grievances, and Appeals - Appealing a Preauthorization Denial for more information.

UTILIZATION REVIEW

PacificSource has a utilization review program to determine coverage of hospital admissions. This program is administered by our Medical Affairs Department. All hospital admissions are reviewed by PacificSource Nurse Case Managers, who are all registered nurses and certified case managers. Questions regarding medical necessity, possible experimental or investigational services, appropriate setting, and appropriate treatment are forwarded to the PacificSource Medical Director, an M.D., for review and determination.

PacificSource reserves the right to delegate a third party to assist with or perform the function of utilization management. In all cases, PacificSource will have final authority in utilization management decisions.

Authorization of Hospital Admissions

When a PacificSource member is admitted to a hospital within the area covered by the PacificSource provider network (see Using the Provider Network - Coverage While Traveling), the hospital's admitting clerk calls PacificSource to verify the patient's eligibility and benefits. The clerk gives us information about the patient's diagnosis, procedure, and attending physician. We use that information to create a daily report of all PacificSource members currently admitted to hospitals within our service area. The authorization status of each admission is documented in the report as either pending, approved, or denied, and the patient's related claims are processed accordingly.

As part of the utilization review process, PacificSource determines how long each patient is expected to remain hospitalized. This is called the "target length of stay." We use the target length of stay to monitor the patient's progress and plan for any necessary follow-up care after the patient is discharged.

The PacificSource Medical Affairs Department assigns the target length of stay based on the patient's diagnosis and/or procedure. For standard hospitalizations, we use written procedures that were developed based on the following guidelines:

- Milliman & Robertson Optimal Recovery Guidelines
- HCIA Length of Stay by Diagnosis & Operation, Western Region, 50th percentile
- Standard of practice in the state of Oregon

If we are unable to assign a length of stay based on those guidelines, our Nurse Case Manager contacts the hospital's utilization review coordinator for more specific information about the case. We then use that information to assign an expected length of stay for the patient.

Extension of Hospital Stays

If a patient's hospital stay extends beyond the assigned length of stay, a Nurse Case Manager contacts the hospital's utilization review coordinator. We obtain current information about the patient's medical progress so we can either extend the length of stay or begin planning for the patient's discharge. The PacificSource Medical Director may review the case to determine if extended hospitalization meets our criteria for coverage.

Occasionally, patients choose to extend their hospital stay beyond the length the attending physician considers medically necessary. Charges for hospital days and services beyond those determined to be medically necessary are the member's responsibility.

Timeliness

When PacificSource receives a request for coverage of an admission or extension of a hospital stay, we are generally able to provide an answer that same day. If we do not have enough information to make a determination, we request further information and attempt to provide a decision on the day we receive that information. If a member is discharged before we receive the information we need, the case is reviewed retrospectively by the Nurse Case Manager and the Medical Director for a decision regarding coverage.

Questions About Specific Utilization Review Decisions

If you would like information on how we reached a particular utilization review decision, please contact our Medical Affairs Department by phone at (541) 684-5584 or (800) 624-6052, or by e-mail at medaffairs@pacificsource.com. We will provide you with a written summary of information we may consider in utilization review of the particular condition, if we in fact maintain such criteria.

CLAIMS PAYMENT

When a PacificSource participating provider treats you, your claims are automatically sent to PacificSource and processed. All you need to do is show your PacificSource ID card to the provider.

If you receive care from a nonparticipating provider, the provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to us for processing. Your claim must include a copy of your provider's itemized bill. It must also include your name, PacificSource ID number or social security number, group name, group number, and the patient's name. If you were treated for an accidental injury, please include the date, time, place, and circumstances of the accident.

All claims for benefits must be turned in to PacificSource within 90 days of the date of service. If it is not possible to submit a claim within 90 days, turn in the claim with an explanation as soon as possible. In some cases PacificSource may accept the late claim. We will never pay a claim that was submitted more than a year after the date of service, though.

All claims should be sent to:

PacificSource
Attn: Claims
PO Box 7068
Eugene OR 97401-0068

Claims Payment Practices

Unless additional information is needed to process your claim, we will make every effort to pay or deny your claim within 30 days of receipt. If a claim cannot be paid within 30 days of receipt because additional information is needed, we will acknowledge receipt of the claim and explain why payment is delayed. If we do not receive the necessary information within 15 days of the delay notice, we will either deny the claim or notify you every 45 days while the claim remains under investigation.

PacificSource has the sole right to pay benefits to the member, the provider, or both jointly. Neither the benefits of this policy nor a claim for payment of benefits under the policy are assignable in whole or in part to any person or entity.

Questions About Claims

If you have questions about the status of a claim, you are welcome to contact the PacificSource Customer Service Department. You may also contact Customer Service if you believe a claim was denied in error. We will review your claim and your group policy to determine if the claim is eligible for payment. Then we will either reprocess the claim for payment, or contact you with an explanation.

Benefits Paid in Error

If PacificSource makes a payment to you that you are not entitled to, or pays a person who is not eligible for payment, we may recover the payment. We may also deduct the amount paid in error from your future benefits.

COORDINATION OF BENEFITS

If you, or your enrolled dependents, are covered by more than one group insurance plan, PacificSource will work with your other insurance carriers to pay up to 100 percent of your covered expenses. This is called “coordination of benefits.” We do this so you receive the maximum benefits available from all sources for the cost of your care. When benefits are coordinated, one plan pays benefits first (the “primary coverage”) and the other pays based on the remaining balance (the “secondary coverage”). If your primary and/or secondary coverage include a deductible, you will be required to satisfy each of those deductibles before benefits are available. This plan’s rules for coordination of benefits were drafted by the National Association of Insurance Commissioners and adopted by the Oregon Department of Consumer and Business Services.

Here is how this plan’s benefits are coordinated with your other coverage:

- If the other plan does not include “coordination of benefits,” that plan is primary and this plan is secondary.
- If you are covered as an employee on one plan and a dependent on another, your employer’s plan is primary.
- When a child is covered under both parents’ policies and the parents are not separated or divorced, the parent whose birthday falls first in a calendar year has the primary plan.
-

EXAMPLE *If your birthday is March 1 and your spouse’s birthday is October 15, your plan is primary for your children.*

When a child is covered under both parents' policies and the parents are separated or divorced:

- If the parent with custody has not remarried, their coverage is primary.
- If the parent with custody has remarried, the custodial parent's coverage is primary, the stepparent's coverage pays second, and the coverage of the natural parent without custody pays third.
- If a court order specifies that one parent is responsible for the child's healthcare expenses, the mandated parent's coverage is primary regardless of custody.

- If a plan covers you as an active employee or a dependent of an active employee, that plan is primary. Another plan covering you as inactive, laid off, or retired is secondary.
- If none of these rules apply, the coverage that has been in place longest is primary.

Most insurance companies send you an explanation of benefits, or EOB, when they pay a claim. If your other plan's coverage is primary, send PacificSource the other plan's EOB with your original bill and we will process your claim. If this plan is primary, send your PacificSource EOB and the original bill to your other insurance company. In most cases that is all the insurer needs to process your claim.

If you receive more than you should when your benefits are coordinated, you will be expected to repay any over-payment.

Coordination with Medicare

- *Employers with 20 or more employees*: For people who are Medicare eligible, this plan is usually primary and Medicare is secondary. This rule only applies to active employees and their enrolled dependents.
- *Medicare disabled and end-stage renal disease (ESRD) patients*: The rule above may not apply to disabled people under 65 and ESRD patients enrolled in Medicare. For information on coordination of benefits in those situations, please contact PacificSource.

THIRD PARTY LIABILITY

Third party liability means claims that are the responsibility of someone other than PacificSource. The liable party may be a person, firm, or corporation. Auto accidents and "slip-and-fall" property accidents are examples of common third party liability cases. If you use this plan's benefits for an illness or injury you think may involve another party, contact PacificSource right away. When we receive a claim that might involve a third party, we will send you a questionnaire to help us determine responsibility.

In all third party liability situations, this plan's coverage is secondary. By enrolling in this plan, you automatically agree to the following terms regarding third party liability situations:

- If PacificSource pays any claim determined to be the responsibility of another party, you will hold the right of recovery against the other party in trust for PacificSource.
- PacificSource is entitled to reimbursement for any paid claims if there is a settlement or judgment from the other party. This is so regardless of whether the other party or insurer admits liability or fault.

- You may subtract a proportionate share of the reasonable attorney's fees you incurred from the money you pay back to PacificSource.
- PacificSource may ask you to take action to recover medical expenses we have paid from the responsible party. PacificSource may also assign a representative to do so on your behalf. If there is a recovery, PacificSource will be reimbursed for any expenses or attorney's fees out of that recovery.
- If you receive a third party settlement, that money must be used to pay your related medical expenses incurred both before and after the settlement. If you have ongoing medical expenses after the settlement, PacificSource may deny your related claims until the full settlement (less reasonable attorney's fees) has been used to pay those expenses.
- In a third party liability situation, PacificSource will ask you to agree to the third party liability terms of the group health policy by signing an agreement. PacificSource is not required to pay benefits until that agreement is signed and returned.

Motor Vehicle and Other Accidents

If you are involved in a motor vehicle accident or other accident, your related medical expenses are not covered by this plan if they are covered by any other type of insurance policy.

PacificSource may pay your medical claims from the accident if an insurance claim has been filed with the other insurance company and that insurance has not yet paid. But before we do that, you must sign a written agreement to reimburse PacificSource out of any money you recover.

By enrolling in this plan, you agree to the terms in the previous section regarding third party liability.

On-the-Job Illness or Injury and Workers' Compensation

This plan does not cover any work-related illness or injury, including those arising from self-employment. This is true regardless of whether workers' compensation benefits are available to you.

PacificSource may pay your medical claims if a workers' compensation claim has been denied on the basis that the illness or injury is not work related, and the denial is under appeal. But before we do that, you must sign a written agreement to reimburse PacificSource out of any money you recover from the workers' compensation coverage.

The contractual rules for third party liability, motor vehicle and other accidents, and on-the-job illness or injury are complicated and specific. Please refer to your group policy for complete details, or contact the PacificSource Third Party Claims Department.

COMPLAINTS, GRIEVANCES, AND APPEALS

Questions, Concerns, or Complaints

PacificSource understands that you may have questions or concerns about your benefits, eligibility, the quality of care you receive, or how we reached a decision or handled a claim. We try to answer your questions promptly and give you clear, accurate answers.

If you have a question, concern, or complaint about your PacificSource coverage, please contact our Customer Service Department. Many times our Customer Service staff can answer your question or resolve an issue to your satisfaction right away.

Unresolved Issues

As a PacificSource member, you can usually find the help you need to resolve outstanding issues simply by calling the PacificSource Customer Service Department.

GRIEVANCE AND APPEAL PROCEDURES

- **Initial Grievance:** If you believe PacificSource has denied benefits to which you are entitled, you may file an initial grievance. You may do so within 180 days from receipt of our notification that your claim is denied in full or in part.
- **First Level of Appeal:** If you have received our response to your initial grievance and you still believe we are in error, you may file an appeal. Your appeal and any additional information you want us to consider should be forwarded to us within 60 days of the initial grievance response.
- **Second Level of Appeal:** If you are not satisfied with the first level appeal decision, you may request an additional review. Your appeal and any additional information not presented with your first appeal should be forwarded to us within 60 days of the first level appeal response.
- **Independent Review:** You may have the right to have your case reviewed by an external independent review organization. If we denied benefits because we determined that services were not medically necessary or were experimental or investigational, you have this right. In addition, if you believe you have a right to continue treatment with a provider who is no longer eligible for payment by PacificSource, your appeal may be reviewed externally. Your request for an independent review must be made within 180 days of the date of the second level of appeal response. External independent review is available at no cost to you, but is only an option for issues of medical necessity, experimental or investigational treatment, and continuity of care after all internal grievance levels are exhausted.

Appealing a Preauthorization Denial

If you believe PacificSource inappropriately denied a preauthorization request, you have the right to appeal the decision. Either you or your healthcare provider can appeal the decision. An appropriate medical consultant, peer review committee, or both will review your appeal. PacificSource will acknowledge your appeal within one week and make a decision on the appeal within 30 days (or sooner if there is an urgent medical situation).

How to Submit Grievances or Appeals

Before submitting a grievance, we suggest you contact our Customer Service Department with your concerns. You can reach us by phone at (541) 684-5582 or toll-free at (888) 977-9299, or by e-mail at cs@pacificsource.com. Issues can often be resolved at this level. Otherwise, you may file a grievance or appeal by:

- **writing** to PacificSource, Attn: Grievance Review, PO Box 7068, Eugene, OR 97401
- **e-mailing** a message to cs@pacificsource.com, with “Grievance” as the subject
- **faxing** your message to (541) 686-2051

If you are unsure of what to say or how to prepare a grievance, please call our Customer Service Department. We will help you through the grievance process and answer any questions you have.

SOURCES FOR INFORMATION AND ASSISTANCE

Assistance in Other Languages

PacificSource members who do not speak English may contact our Customer Service Department for assistance. We can usually arrange for a multilingual staff member or interpreter to speak with them in their native language.

Para asistirle en español, por favor llame el numero (800) 624-6052, extensión 1009, de Lunes a Viernes, 8:00 a.m. hasta 5:00 p.m.

Assistance Outside PacificSource

If you believe we have not responded to your grievance appropriately, you have the right to file a complaint or seek other assistance from the Oregon Insurance Division. You may contact them by calling (503) 947-7984, or writing to the Oregon Insurance Division, Consumer Protection Unit, 350 Winter Street NE, Room 440-2, Salem OR 97310, or on the Internet at www.cbs.state.or.us/external/ins/

Information Available from PacificSource

PacificSource makes the following written information available to you free of charge. You may contact our Customer Service Department by phone, mail, or e-mail to request any of the following:

- A directory of participating healthcare providers under your plan
- Information about our drug formulary, if your plan benefits include coverage for prescription drugs
- A copy of our annual report on complaints and appeals
- A description (consistent with risk-sharing information required by the federal Health Care Financing Administration) of any risk-sharing arrangements we have with providers
- A description of our efforts to monitor and improve the quality of health services
- Information about how we check the credentials of our network providers and how you can obtain the names and qualifications of your healthcare providers
- Information about our preauthorization and utilization review procedures

Information Available from the Oregon Insurance Division

The following consumer information is available from the Oregon Insurance Division:

- The results of all publicly available accreditation surveys
- A summary of our health promotion and disease prevention activities
- Samples of the written summaries delivered to PacificSource policyholders
- An annual summary of grievances and appeals against PacificSource
- An annual summary of our utilization review policies
- An annual summary of our quality assessment activities
- An annual summary of the scope of our provider network and accessibility of healthcare services

You can request this information by contacting the Oregon Insurance Division, Consumer Protection Unit, 350 Winter Street NE, Room 440-2, Salem, OR 97310, phone (503) 947-7984, Web www.cbs.state.or.us/external/ins/.

FEEDBACK AND SUGGESTIONS

As a PacificSource member, you are encouraged to help shape our corporate policies and practices. We welcome any suggestions you have for improving your plan or our services. You may send comments or feedback using the "Contact Us" form on our Web site, www.pacificsource.com. You may also write to us at:

PacificSource
Attn: Vice President of Operations
PO Box 7068
Eugene OR 97401-0068

RIGHTS AND RESPONSIBILITIES

PacificSource is committed to providing you with the highest level of service in the industry. By respecting your rights and clearly explaining your responsibilities under this plan, we will promote effective healthcare.

Your Rights as a Member:

- You have a right to receive information about PacificSource, our services, our providers, and your rights and responsibilities.
- You have a right to expect clear explanations of your plan benefits and exclusions.
- You have a right to be treated with respect and dignity.
- You have a right to impartial access to healthcare without regard to race, religion, gender, national origin, or disability.
- You have a right to honest discussion of appropriate or medically necessary treatment options. You are entitled to discuss those options regardless of how much the treatment costs or if it is covered by this plan.
- You have a right to the confidential protection of your medical records and personal information.
- You have a right to voice complaints about PacificSource or the care you receive, and to appeal decisions you believe are wrong.
- You have a right to participate with your healthcare provider in decision-making regarding your care.
- You have a right to know why any tests, procedures, or treatments are performed and any risks involved.
- You have a right to refuse treatment and be informed of any possible medical consequences.
- You have a right to refuse to sign any consent form you do not fully understand, or cross out any part you do not want applied to your care.
- You have a right to change your mind about treatment you previously agreed to.

Your Responsibilities as a Member:

- You are responsible for reading this benefit handbook and all other communications from PacificSource, and for understanding your plan's benefits. You are responsible for contacting PacificSource Customer Service if anything is unclear to you.
- You are responsible for making sure your provider obtains preauthorization for any services that require it before you are treated.
- You are responsible for providing PacificSource with all the information required to provide benefits under your plan.
- You are responsible for giving your healthcare provider complete health information to help accurately diagnose and treat you.
- You are responsible for telling your providers you are covered by PacificSource and showing your ID card when you receive care.
- You are responsible for being on time for appointments, and calling your provider ahead of time if you need to cancel. You are responsible for any fees the provider charges for late cancellations or "no shows."
- You are responsible for following the treatment plans or instructions agreed on by you and your healthcare provider.
- You are responsible for contacting PacificSource if you believe you are not receiving adequate care.

PRIVACY AND CONFIDENTIALITY

PacificSource has strict policies in place to protect the confidentiality of your personal information, including your medical records. Your personal information is only available to the PacificSource staff members who need that information to do their jobs.

Disclosure outside PacificSource is allowed only when necessary to provide your coverage, or when otherwise allowed by law. Except when certain statutory exceptions apply, Oregon law requires us to have written authorization from you (or your representative) before disclosing your personal information outside PacificSource. An example of one exception is that we do not need written authorization to disclose information to a designee performing utilization management, quality assurance, or peer review on our behalf.

PLAN ADMINISTRATION

Group Insurance Contract

This plan is fully insured. Benefits are provided under a group insurance contract between your employer and PacificSource Health Plans. Your employer—the policyholder—has a copy of the group insurance contract, which contains specific information regarding eligibility and benefits. Under the insurance contract, PacificSource—not the policyholder—is responsible for paying claims. However, the policyholder and PacificSource share responsibility for administering the plan's eligibility and enrollment requirements. The policyholder has given PacificSource discretionary authority to determine eligibility for benefits under the plan and to interpret the terms of the plan.

If there are any conflicts between this benefit book and the group health contract, the group health contract will govern.

Our address is:

PacificSource Health Plans
PO Box 7068
Eugene OR 97401-0068

Plan Funding

Insurance premiums for employees are paid in whole or in part by the plan sponsor (your employer) out of its general assets. Any portion not paid by the plan sponsor is paid by employee payroll deductions.

Plan Changes

The terms, conditions, and benefits of this plan may be changed from time to time. The following people have the authority to accept or approve changes or terminate this plan:

- The policyholder's board of directors or other governing body
- The owner or partners of the business
- Anyone authorized by the above people to take such action

The plan administrator is authorized to apply for and accept policy changes on behalf of the policyholder. If changes occur, PacificSource will provide your plan administrator with information to notify you of changes to your plan. Your plan administrator will then communicate any benefit changes to you.

If your group policy terminates and your employer does not replace the coverage with another group policy, your employer is required by law to advise you in writing of the termination. When this policy terminates, PacificSource will notify your employer about any continuation or portability coverage available to you.

Legal Procedures

You may not take legal action against PacificSource to enforce any provision of the group contract until 60 days after your claim is submitted to us. Also, you must exhaust this plan's claims procedures before filing benefits litigation. You may not take legal action against PacificSource more than three years after the deadline for claim submission has expired.